COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
ADULT OUTPATIENT AND RESIDENTIAL
SUBSTANCE ABUSE SERVICES RATE STUDY

Presented to:
Ms. Wendy L. Watanabe
Auditor-Controller
County of Los Angeles
500 West Temple Street, Room 525
Los Angeles, California 90012

Final Rate Study Report : August 25, 2011

MGT OF AMERICA, INC.

PUBLIC CONSULTING GROUP

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MGT OF AMERICA, INC.

August 25, 2011

Wendy L. Watanabe
Auditor-Controller
County of Los Angeles
500 West Temple Street, Room 525
Los Angeles, California 90012

Dear Ms. Watanabe:

MGT of America, Inc. (MGT) and its subcontractor Public Consulting Group, Inc. (PCG) are pleased to submit our final report for the 2010-11 County of Los Angeles Department of Public Health Substance Abuse Prevention and Control (SAPC) Adult Outpatient and Residential Substance Abuse Services Rate Study. This rate study was conducted in accordance with Work Order No. 7-77A and corresponding due date extensions. We have also provided copies of the report to Timothy Duenas, Director of Community Planning and Program Evaluation at SAPC.

Please contact me at (916) 443-3411 if you have any questions about the report's contents or if you would like to discuss the rate study in more detail.

Sincerely,

Linus Li

Linus Li
Principal

Enclosures

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SECTION I–EXECUTIVE SUMMARY

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The County of Los Angeles (County) Department of Public Health's mission is to protect health, prevent disease, and promote the health and well-being of County residents. One area in which the department adheres to its mission is by addressing health threats associated with substance use disorders. The department's Substance Abuse Prevention and Control (SAPC) program supports this mission by administering contracts with over 180 community-based agencies (providers) that offer an array of treatment and recovery services.

Provider rate reforms can be invaluable tools to effect change. Not only can they be used to establish provider payments, they can incent desired services to patients, impact the level of credentialing within a provider community, help control budgets and expenditures, and be the impetus for systemic service delivery changes. In recognizing the importance and value of revisiting its rate structure, the County sought the assistance of an external firm to conduct a comprehensive rate study of its adult outpatient and residential substance abuse services.

Through a competitive procurement process, MGT of America, Inc. (MGT) and its subcontractor Public Consulting Group, Inc. (PCG) were awarded the project to develop a rate study that would address the following elements:

- Determine the actual costs associated with providing adult outpatient and residential substance abuse program services within the County;
- Develop rates for adult outpatient and residential substance abuse services, and
- Focus broadly on developing service descriptions, and identify barriers, disincentives, and recommendations for SAPC.

During the five-month study, the MGT team embarked upon a comprehensive plan of involving the SAPC provider community, utilizing the expertise within SAPC, developing a Web-based cost reporting tool to assist in analyzing costs, and conducting extensive analysis of similar service systems and appropriate rate methodologies from around the country to develop a rate study that is comprehensive in nature, yet provides the utility SAPC needs for future provider contracts. The MGT team was able to overcome limitations in provider data to successfully develop a rate study that matches the vision described during the procurement process, and that meets the requirements set forth by the County. The rate study contained herein will allow SAPC to establish adult outpatient and residential substance abuse service rates for its provider community and recommends changes to the service delivery system that will well-position SAPC for the future.

ANALYSIS AND FINDINGS

The MGT team conducted an extensive analysis of comparable service delivery models, SAPC's existing service modalities, and the costs within SAPC's provider community. Our findings helped to formulate the recommendations in our study. For example, the MGT team's analysis of similar fee-for-service (FFS) models around the country found that it is imperative for the provider community when establishing rates to take into account the full cost of providing services. In addition, while the change to a FFS model may be problematic for some providers, the overall administrative time and expense to providers in the long run, are relatively low.

In addition, during the analysis of the current SAPC service modalities, the MGT team found that 10 of the 17 modalities (58.9%) had some form of service bundling as part of the service delivery component. We also found that the current credentialing within the provider community was in line with many billing protocols for similar FFS procedures.

Finally, the analysis of the cost reports revealed that there was a wide range of cost variability across different cost factors. In addition, we determined that there may be some limitations in the current cost reporting process to establishing cost-based rates. Such limitations include providers throughout the system that are not consistently capturing cost and utilization data by modality.

RECOMMENDATIONS

The MGT team's analysis shaped our overall recommendation to have SAPC move towards a FFS procedural coding model for the provider community in the future. Under this structure, the providers would bill SAPC for the following procedure codes and SAPC would pay providers up to a predetermined limit, based on available funding.

Recommended SAPC Procedure Codes	
H0001 Assessment	**H0048 Alcohol and/or Drug Testing**
H0003 Laboratory Analysis	**H0049 Alcohol and/or Drug Screening**
H0004 Individual Counseling	**H0050 Brief Intervention**
H0005 Group Counseling	**J2315 Naltrexone**
H0006 Case Management	**S0281 Medical Home Care Coordination Maintenance**
H0010 Sub-Acute Detoxification (Medically Monitored)	**S5190 Wellness Assessment**
H0012 Sub-Acute Detoxification (Clinically Managed)	**S9075 Smoking Cessation Treatment**
H0015 Day Care Habilitative Treatment	**S9976 Lodging**
H0016 Medical Intervention in an Ambulatory Setting	**T1007 Treatment Plan Development/Modification**
H0017, H0018, H0019 Residential Treatment Program	**T1012 Skills Development**
H0020 HG, Methadone Administration	**99203, 99204, 99205 Physical Evaluation/Exam**
H0022 Intervention Services	**X9999 Residential Room and Board**

The MGT team also developed a number of short- and long-term recommendations for SAPC's consideration. The implementation of these recommendations will result in a streamlined, Healthcare Common Procedure Coding System (HCPCS)-based billing and reporting system that effectively captures significant cost variables, reflecting the true cost of providing substance abuse treatment in Los Angeles County.

1. Institute Fee-For-Service Rates for Adult Populations

SAPC should implement the fee-for-service (FFS) rates identified in the Rate Study for adult populations. Providers in the SAPC network will need to be informed immediately so they can begin to prepare for the administrative changes that will impact budgeting, cash flow, and overall program operations with the implementation of these rates. In conjunction with the implementation of these rates, SAPC should develop a training program to assist the providers through this transition. Providers will have a host of changes to administrative activities, such as billing and cost reporting, that will be impacted by the change, and they will need time to transition to the new FFS system.

The attached fee schedule represents the proposed fiscal year (FY) 2012 rates for SAPC services:

		Staff Modified Rate				Population Modified Rate				
Recommended SAPC Procedure Codes	**Base Rate**	**A1**	**A2**	**A3**	**A4**	**HH**	**HD**	**H9**	**HL**	**HI**
H0001 Assessment	$75.99	$89.42	$96.64			$83.59	$83.59	$83.59	$83.59	$83.59
H0003 Laboratory Analysis	$12.26					$13.48	$13.48	$13.48	$13.48	$13.48
H0004 Individual Counseling	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
H0005 Group Counseling (Per person in group)	$4.75	$5.59	$6.04			$5.22	$5.22	$5.22	$5.22	$5.22
H0006 Case Management	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
H0010 Sub-Acute Detoxification (Medically Monitored)	Cost*									
H0012 Sub-Acute Detoxification (Clinically Managed)	Cost*									
H0015 Day Care Habilitative Treatment	$83.39	$100.18	$109.19			$91.73	$91.73	$91.73	$91.73	$91.73
H0016 Medical Intervention in an Ambulatory Setting	$39.20			$49.82		$43.12	$43.12	$43.12	$43.12	$43.12
H0017, H0018, H0019 Residential Treatment Program	$43.13					$47.44	$47.44	$47.44	$47.44	$47.44
H0020 HG, Methadone Administration	$14.58			$21.66	$44.93	$16.04	$16.04	$16.04	$16.04	$16.04
H0022 Intervention Services	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
H0048 Alcohol and/or Drug Testing	$18.39					$20.23	$20.23	$20.23	$20.23	$20.23
H0049 Alcohol and/or Drug Screening	$16.10	$19.46	$21.26			$17.71	$17.71	$17.71	$17.71	$17.71
H0050 Brief Intervention	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
J2315 Naltrexone per mg	$2.83					$3.11	$3.11	$3.11	$3.11	$3.11
S0281 Medical Home Care Coordination Maintenance	TBD									
S5190 Wellness Assessment	$74.16			$106.03	$210.76	$81.57	$81.57	$81.57	$81.57	$81.57
S9075 Smoking Cessation Treatment	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
S9976 Lodging	negotiated									

Continued

		Staff Modified Rate				Population Modified Rate				
Recommended SAPC Procedure Codes	**Base Rate**	**A1**	**A2**	**A3**	**A4**	**HH**	**HD**	**H9**	**HL**	**HI**
T1007 Treatment Plan Development/Modification	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
T1012 Skills Development	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
99203 Physical Evaluation/Exam (30min)	$114.50					$125.95	$125.95	$125.95	$125.95	$125.95
99204 Physical Evaluation/Exam (45min)	$174.33					$191.76	$191.76	$191.76	$191.76	$191.76
99205 Physical Evaluation/Exam (60min)	$216.35					$237.99	$237.99	$237.99	$237.99	$237.99
X9999 Residential Room and Board	$70.71					$77.78	$77.78	$77.78	$77.78	$77.78

Legend

Modifier Code	Staffing Modifier
A1	Primary Service by Licensed Counselor
A2	Primary Service by Marriage and Family Therapist
A3	Primary Service by Registered Nurse
A4	Primary Service by Physician

Modifier Code	Population Modifier
HH	Co-Occurring Mental Health Disorders
HD	Pregnant/Parenting Women
H9	Court Ordered
HL	Monolingual
HI	Homeless

There are currently only two providers with a total of four SAPC contracts to provide the following services:

H0010 Sub-Acute Detoxification (Medically Monitored)
H0012 Sub-Acute Detoxification (Clinically Managed)

The recommended rate for these services is reported cost, based on the filed cost reports. The calculated rates for each contract are as follows:

Agency	Contract #	Rate per Day
BHS ARC	H-801603E	$300.53
BHS RGM	H-801603B	$349.87
Tarzana 1	H-702267B	$381.35
Tarzana 2	PH-000918D	$368.62

2. Implement a SAPC Management Information System

Providers will now be responsible for submitting claims to SAPC on a FFS basis. To be able to accommodate those billings, SAPC will need to develop the internal protocols and systems to do so, including developing a modified Centers for Medicare and Medicaid Services (CMS) CMS-1500 claim form from providers. The CMS-1500 form is a standard claim form used in the Medicare program. The SAPC system should have the ability to accept and pay providers based on the claim form, and the system needs to be able to monitor utilization to identify trends and risk areas, given the fixed budget that SAPC has for provider services. Prior authorization programs may need to be implemented should providers over or under bill.

In addition, providers may need to invest in their information systems for utilization tracking, reporting, and bill submission. Moving to a FFS model is not an insignificant event for the providers, and it may be costly.

3. Implement a Cost Reporting System That Supports the FFS Environment

Streamline Provider Position Titles

Position titles play a crucial role in the determination of rates as higher levels of credentialing tend to warrant higher personnel expenditures, and thus, a higher reimbursement for services rendered. For example, for reasons related to the complexity of the client's condition, there is value added when a licensed psychologist provides an individual counseling session rather than a registered counselor. The rates for these services can reflect that value and incentivize the use of more highly qualified staff. Determining an appropriate rate increase based on staff credentials requires a streamlined process for classifying staff.

Currently, there are 834 unique position titles within the cost report database. The addition of position titles on a free form basis reduces their value in the report as it diminishes the ability to compare staff ratios across providers. The MGT team recommends instituting a drop-down list of predetermined position titles with each title providing enough detail on the staff member's qualifications to warrant an accurate rate reflection.

Specify Full Time Equivalent (FTE) for Each Service

An accurate FTE count can be used to analyze both provider productivity and the efficiency of services rendered. As part of the cost report revision process, the MGT team requested that agencies provide an FTE count for each salary entered on the cost report. Several providers called the cost report helpline with questions on this requirement, and the analysis suggests that a subset of providers entered FTE counts inaccurately. The MGT team recommends that SAPC require the inclusion of FTEs as part of regular reporting practices and provide training (where needed) on how to accurately calculate this number.

Provide Greater Definition Around the Reporting of Administrative Costs

It would be acceptable for providers to report administrative costs as directly allocated through cost report schedule P1a, which includes costs for program staff, or indirectly through the use of cost report schedule P5, which explicitly requires administrative cost information. However, SAPC needs to be able to discretely identify all administrative costs being charged to contracts so that appropriate comparisons and cost limitations can be established. If SAPC wishes to implement a uniform cost reporting system, they must develop better definitions and instructions about the reporting of costs and cost allocation.

Document Service-Related Costs at the Level of HCPCS Definitions

With the goal of instituting a reporting system based on HCPCS coding, the MGT team recommends that SAPC providers begin tracking units and costs internally, at a level consistent with the recommended HCPCS coding structure as soon as possible. Significant changes to the current method of tracking units and costs will include the breakout of room and board from all other residential costs; and separate tracking for case management, screening, assessment, and drug testing related costs. Completing this shift in operations will require varying lengths of time depending on provider resources and current tracking methods. However, once complete, these costs will provide a very strong basis for the determination of rates in future years.

Document Services Provided to Special Populations

As described previously, treating special populations, including individuals who are Human Immunodeficiency Virus (HIV) positive, indigent, court-referred, mothers, or pregnant, results in a per-unit cost increase. To capture these additional costs, providers will need to document the treatment of these individuals and classify costs accordingly.

4. Develop an Appeals Process for Costs that Exceed the Established Rate by Service Code

SAPC will experience some providers that are adversely affected by the rate changes. This could occur for a number of reasons including that historic rates were set too high; the provider lacks a true information system to track cost and utilization; the provider cannot adapt quickly enough to manage

new cash flow demands; etc. It is not the goal of SAPC to put these providers out of business, so SAPC will need to develop a process to manage these "hardship" providers that is fair and equitable to the entire provider network.

5. Implement Long-Term Recommendations

The MGT team has discussed numerous methodologies, which (because of complexity and scope) will require a long-term strategy to implement. These themes are pervasive throughout this study and should be considered part of a comprehensive plan. These ideas include annually collecting cost and utilization data, establishing rates, and providing support for providers' FFS billing operations and rate establishment. SAPC will be moving to a new FFS payment system that will require tighter fiscal and administrative controls not only for SAPC, but for the provider community as well. The reimbursement process will become a true revenue cycle and will need to be proactively managed for efficiency and economy.

SAPC should also consider developing a quality-based payment method in future years. Quality-based payment methodologies, otherwise known as "Pay for Performance (P4P)" have achieved increasing interests and support from providers and insurers in the United States health care system in recent years. SAPC should review national policies on quality-based payment for substance abuse treatment programs and move to identify and build an action plan to build P4P measures into the system. The Centers for Medicare and Medicaid Services recently implemented quality payment standards for hospitals that measure compliance and outcomes of heart attack, heart failure, infection control, pneumonia, and patient satisfaction. These measures will be utilized to create a P4P payment system for hospital payments for Medicare recipients. Similar payment programs are being developed by public/private payers for institutional and non-institutional service settings across the country. SAPC could work to develop a similar program for the network of substance abuse providers in Los Angeles County.

SECTION II–INTRODUCTION

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The County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control (SAPC) provides Los Angeles County children, adolescents, and adults with alcohol and other drug (AOD) treatment services.[1] The SAPC administers contracts with over 300 community-based agencies, known as providers, and had a FY 2009-10 budget of over $200 million. For the purposes of the Adult Outpatient and Residential Substance Abuse Services Rate Study (Rate Study), the MGT team is focusing only on the adult population served by SAPC in the 17 different adult outpatient and substance abuse service modalities provided to SAPC clients across the county. While focusing on only a subset of all SAPC services, the adult outpatient and residential substance abuse services account for over $144 million spent on residents of Los Angeles County as part of over 480 contracts and 180 providers.

Providers deliver an array of AOD treatment services to predominantly uninsured or underinsured clients through a network of community assessment service centers, day care habilitative facilities, outpatient counseling centers, alcohol and drug-free living centers, residential programs, and other programs across the 4,100 square miles that is Los Angeles County. The provider network maintained by SAPC includes public, private, and not-for-profit entities that provide the 17 core adult outpatient and residential substance abuse treatment services. In fiscal year 2009-10, SAPC paid providers over $144 million for adult outpatient and residential substance abuse services from a combination of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, state general funds, interdepartmental resources, and Net County Costs. Each provider maintains one or more contracts with SAPC to provide the adult outpatient and residential substance abuse services.

The SAPC contracts with each provider to provide one or more of the following 17 service modalities:

1. **Alcohol and Drug-Free Housing**: Transitional housing that provides affordable, safe, and supported living environments for no more than six individuals who are recovering from substance use.
2. **Case Management**: Participant-centered, goal-oriented service that includes assessment of participant needs for particular services; assisting the participant in obtaining services; and reviewing participant accomplishments, outcomes, and barriers.
3. **Community Assessment and Service Center Program:** Provides an assessment of a participant's substance use and mental health disorders using a standardized and computerized substance abuse and mental health assessment tool.
4. **Day Care Rehabilitative:** Outpatient and rehabilitation services provided at least three hours per day, three days per week to persons with substance abuse diagnoses.
5. **Human Immunodeficiency Virus (HIV) Early Intervention Services:** Provides HIV early intervention services to eligible clients.

[1] Information for Section II. Introduction comes from "Substance Abuse Prevention and Control Strategic Plan 2011-2016," County of Los Angeles Department of Public Health, February 2011; and "Work Order Request No. 7-77A," County of Los Angeles Department of Auditor-Controller, July, 2010.

6. **Outpatient Drug-Free Individual Counseling:** Services include screening, assessment, development of treatment plans, individual counseling, urinalysis testing, and vocational or other educational activities for adults.
7. **Outpatient Drug-Free Group Counseling:** Services include screening, assessment, development of treatment plans, group counseling, urinalysis testing, and vocational or other educational activities for adults.
8. **Outpatient Drug Court Treatment and Recovery Services:** Outpatient programs for adults that provide a comprehensive and integrated program of treatment and rehabilitation services, which are consistent with accepted Los Angeles County Drug Court standards and practices.
9. **Outpatient Narcotic Treatment Program (all types):** Programs that administer pharmacological treatment accompanied by ancillary medical and social services for individuals 18 years of age or older, with a history of two or more failures in alternative treatment programs.
10. **Outpatient Narcotic Treatment Program (methadone detoxification):** Programs that administer methadone in decreasing doses for a period not to exceed 21 days to assist an individual's withdrawal from dependency on heroin or other morphine-like drugs.
11. **Residential:** Twenty-four hour program within a licensed facility for adults 18 years of age or older, providing services that may include intake, assessment, screening, individual and group counseling, crisis intervention, self-help groups, social and recreational activities, and urinalysis testing.
12. **Residential/Recovery Short Term:** Residential program within a licensed facility for adults 18 years of age or older for up to 30 days.
13. **Residential/Recovery Long Term:** Residential program within a licensed facility for adults 18 years of age or older for 31 days or longer.
14. **Residential Detoxification:** Residential program that provides for safe withdrawal and transition to ongoing treatment.
15. **Hospital Inpatient Detoxification:** Residential medical detoxification services directed toward the care and treatment of persons suffering from the toxic effects of alcohol, narcotics, and other dangerous drugs.
16. **Satellite Housing Center:** The facility provides safe and stable, alcohol and drug-free housing for pregnant women and their children while they participate in a perinatal treatment and recovery program.
17. **Training:** Training and technical assistance services are a broad range of activities to educate and instruct Los Angeles County contracted providers on strategies to improve existing treatment, service delivery, and prevention/education services in the field of substance abuse.

The service modalities identified above not only define what services providers can provide to clients and the services for which SAPC will pay, but they are the basis or cost centers by which providers must currently report expenditures at the end of the fiscal year. This information as reported by the SAPC providers was the basis for the analysis conducted by the MGT team for use in developing the rates as part of the Rate Study.

In the following sections of the Rate Study the MGT team: defines the scope and components of the study (Section III. Scope of Study); summarizes a review of comparable system models (Section IV. Review of Comparable FFS Models); provides standardized service definitions for SAPC in the future (Section V. Standardized Service Definitions); details standards of care related to those future services (Section VI. Standards of Care); conducts an analysis of existing provider costs (Section VII. Cost Identification and Analysis); develops existing and future rates and recommendations for SAPC (Section VIII. Rate Development and Recommendations); and identifies barriers and other recommendations (Section IX. Barriers, Disincentives, and Recommendations).

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SECTION III–SCOPE OF STUDY

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In July 2010, the County of Los Angeles Department of Auditor-Controller issued a Work Order Request (WOR No. 7-77A) for the SAPC Adult Outpatient and Residential Substance Abuse Rate Study. Through a competitive procurement process, MGT and its subcontractor PCG, were awarded the work to develop a Rate Study. As defined by the Auditor-Controller, the Rate Study includes the following objectives:[2]

- Conduct a comprehensive study to determine the actual costs associated with providing adult outpatient and residential substance abuse program services within the County.

- Develop rates for adult outpatient and residential substance abuse services. The Rate Study shall factor in the location of program services within the eight geographic County Service Planning Areas (SPA). The Rate Study will also determine if the location of a facility in the County or other cost adjustment factors will result in different rates within the County. The rates developed should reflect the average range of costs for each Service Modality provided by SAPC. For reference throughout the document, the following table summarizes the Los Angeles County health districts and their associated SPA.

	Health Districts
SPA 1	Antelope Valley
SPA 2	East Valley
	Glendale
	San Fernando
	West Valley
SPA 3	Alhambra
	El Monte
	Foothill
	Pasadena
	Pomona
SPA 4	Central
	Hollywood/Wilshire
	Northeast
SPA 5	West
SPA 6	Compton
	South
	Southeast
	Southwest
SPA 7	Bellflower
	East Los Angeles

Continued

[2] Information for Section III Scope of Study comes from "Work Order Request No. 7-77A," County of Los Angeles Department of Auditor-Controller, July, 2010.

	Health Districts
SPA 7	San Antonio
	Whittier
SPA 8	Harbor
	Inglewood
	Long Beach
	Torrance

- The Rate Study shall focus broadly on developing service descriptions and rates, and identifying barriers, disincentives, and recommendations.

As part of the project kickoff for the Rate Study, the MGT team presented a detailed work plan that identified the work steps involved in completing the objectives identified above and detailed in the Work Order Request. As part of this work plan, we presented our approach to gathering feedback from the provider community and utilizing a Web-based cost-reporting tool designed specifically for the SAPC Rate Study. By involving the provider community, the MGT team believed that it would improve the overall outcomes of the Rate Study.

1: PROVIDER FOCUS GROUPS

To help gather information to complete all of these aspects of the Rate Study, and improve the outcomes of the Rate Study, the MGT team reached out to the SAPC provider community in a series of focus group sessions. In December 2010, the MGT team met with SAPC providers to gain a better understanding of the SAPC service delivery system and the financial reporting capabilities of SAPC providers. The information gathered during the focus groups was used to guide our recommendations and findings for the overall Rate Study.[3] The MGT team's approach during the focus group sessions was to discuss, by Service Modality:

- Service Modality definitions and understanding by providers.
- How services are provided and if there are any "value-added" service components not necessarily paid by SAPC.
- Components of the services provided that could be bundled or unbundled.
- Service delivery and financial impacts related to moving to HCPCS/Current Procedural Terminology (CPT) procedure coding.
- Staffing levels and credentialing.
- Populations served and how providers track utilization.
- Unique circumstances impacting service delivery.

[3] Information from "SAPC Provider Focus Group Notes and Comments," MGT team, January 2011.

- Accuracy of costs reported on the cost reports.
- Accounting/cost reporting capabilities as they relate to bundling and unbundling of services.
- Other pertinent items for each Service Modality.

The MGT team had four focus groups encompassing all of the SAPC SPAs, and by the end, over 30 providers attended the focus groups. The information and comments gathered from the focus groups helped the MGT team to structure the overall approach to the Rate Study, as well as in the development of recommendations for SAPC. There were several themes that permeated the focus groups including the following:

- Participants questioned the purpose of the study and had concerns that the study will simply reallocate services to other providers depending on if the rates are determined to be higher or lower than the current rates, given the static or shrinking amount of funding from SAPC.
- Unbundling of services may have financial impacts for some providers if they cannot adequately account for costs and bill in a way that is required.
- The current cost reporting process does not capture all costs for the provider and may be problematic in establishing current and future rates.

The information from these focus group sessions was used to develop the MGT team's recommendations for the Rate Study.

2: COST REPORT VALIDATION

In addition to the focus groups, the MGT team developed a Web-based cost-reporting tool that allowed all providers to validate pre-populated cost information from the FY 2009-10 SAPC cost report, and to provide additional information necessary to complete the Rate Study. This Web-based tool was another way to involve the provider community in the Rate Study to improve the overall outcomes, and to gather information necessary to assist the MGT team in developing appropriate rates.

The MGT team provided training to all providers on the Web-based cost reporting tool as well as access to toll-free telephone and email assistance, as providers were reviewing and completing the cost report on-line. By the end of the cost reporting process, over 20 providers either contacted the MGT team or validated cost information via the Web-based application.

Limitations

The identification and availability of cost and utilization data for the SAPC rate analysis was a recognized challenge to this scope of work. Providers throughout the system did not consistently capture cost and utilization data by modality or the new standards of care definitions. MGT provided cost report forms for all SAPC providers to fill out with updated FTE, units, and cost allocations consistent with discrete level reporting of all modalities. At the end of the Web-based cost reporting time period, 24 agencies had participated in the process (22% of all providers). While the MGT team and SAPC preferred to have 100% participation in the cost reporting process, we were still able to glean some statistics from this

data, such as the percent split of administrative, other direct, fixed, and direct service costs. Nevertheless, SAPC and the MGT team recognize the administrative burden associated with this effort and were generally satisfied with the level of participation and results.

The goal of future rate updates needs to be 100% reporting and data collection for all providers. With detailed FTE, cost, and utilization data, SAPC will be able to develop annual rates that are cost-related and market-based.

3: RESEARCH AND ANALYSIS

In conjunction with provider input into the Rate Study process, the MGT team conducted thorough research and analysis to augment the information being obtained from the providers and the cost reports. As detailed in each section of the Rate Study, the MGT team contacted officials from comparable systems around the country to gather information that helped inform our review of FFS models. In addition, we conducted extensive research of national and California procedural codes to develop the standardized service definitions and standards of care. Finally, in the development of the rates and recommendations for the SAPC system, the MGT team researched proven rate development methodologies in the development of the recommended SAPC rates. The research and analysis that was conducted by the MGT team helped validate or redirect the team's assumptions in developing sound recommendations for SAPC.

4: FINAL REPORT

Utilizing the information obtained through provider input and independent research over the course of the Rate Study, the MGT team provided SAPC with interim deliverables for review and comment. The interim deliverables ultimately became sections of the overall Rate Study, and included:

- Review of Comparable FFS Models
- Standardized Service Definitions
- Standards of Care
- Cost Identification and Analysis, and Rate Development Methodology
    - Recommendations for SAPC Rates
    - Identification of Barriers, Disincentives, and Recommendations

The MGT team reviewed suggested changes from SAPC and revised the interim deliverables to incorporate those suggestions. The culmination of these efforts by the MGT team is the development of the Rate Study that is contained herein. The goal of the Rate Study is to address the needs of SAPC and the Auditor-Controller through focusing on improvements to the rate setting process, and providing the following specific deliverables:

- Development of the following schedules:
    - FFS rates for each Service Modality.

  - Schedule of Cost Factors and a narrative detailing the criteria used to develop those factors.
  - Schedule of services that are commonly reimbursed by third-party payers.
- Review of comparable FFS models.
- Standardized service definitions.
- Review of standards of care.
- Direct staff wages, employment-related expenditures, program-related expenditures, and general and administrative expenditures.
- Rate development methodology.
- Effectiveness of bundling and unbundling services.
- Results of contacting providers.
- Sliding fee scale.
- Project impact of proposed FFS rates on SAPC's budget.
- Schedule by SPA of current and proposed rates.
- Guidelines for collection of client fees.
- Recommendations and next steps for implementing the Rate Study in future contract action, etc.
- Appropriate methodology for future changes to contracted rates.
- Recommendations on which services should be unbundled.
- Schedule of recommended service rates and standard service definitions for each unbundled service.
- Barriers including financial disincentives to service delivery.

In the following sections of the Rate Study, the MGT team addresses each of the requirements of the final report, and the overall requirements of this Work Order Request.

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SECTION IV-REVIEW OF COMPARABLE FFS MODELS

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1: INTRODUCTION

The County of Los Angeles Department of Public Health, SAPC, manages over 480 contracts and associated exhibits for over 180 providers, offering adult outpatient and residential substance abuse services. As part of the Rate Study, the MGT team conducted research on comparable adult substance programs throughout the United States that use FFS models similar to those in Los Angeles. The MGT team conducted in-depth interviews with and performed detailed analysis of the following four counties:

- King County, Washington (King)
- Orange County, California (Orange)
- San Diego County, California (San Diego)
- Riverside County, California (Riverside)

The MGT team also identified and interviewed other states and counties whose program models, service delivery, and costing systems are substantially different from those of Los Angeles, but nonetheless provided useful information relevant to SAPC, including:

- State of Illinois (Illinois)
- State of Florida (Florida)
- Miami-Dade County, Florida (Miami)
- Broward County, Florida (Broward)

We selected Illinois as an interview candidate because local providers contract directly with the state, but did not include Illinois in our in-depth analysis because the state does not provide the full range of substance abuse services. Similarly, we interviewed representatives from Florida, Broward, and Miami because the state and counties both provide substance abuse services, but did not include them in our in-depth analysis because none of them individually provides the full range of substance abuse services comparable to Los Angeles.

We also attempted to interview staff from other comparable counties and cities but were unsuccessful due to the unresponsiveness of these entities to our requests for interviews:

- City of San Francisco, California
- Harris County, Texas
- City of Houston, Texas
- Cook County, Illinois
- City of Chicago, Illinois
- New York City, New York

Our research focused on identifying characteristics of FFS models, reviewing the strengths and weaknesses of the models, and identifying costing approaches that counties have successfully implemented.

The following sections provide an overview of the comparable counties' substance abuse programs, a description of five common FFS costing approaches, examples of major cost drivers, and the strengths and weaknesses of the FFS model. In addition, the MGT team compared the analysis of the comparable counties' models to the Los Angeles model to help illustrate the strengths and weaknesses of its FFS methodology.

Overview of County Substance Abuse Programs

The counties that we interviewed deliver substance abuse services through a combination of community-based providers and internal county services, with some variations. For instance, Riverside uses county staff to deliver a range of outpatient services through county-run clinics, while San Diego outsources virtually all of its substance abuse services. The variance in ratio of internal services to provider resources in large part appears to be due to historical precedence, previous grant mandates, and grant funding requirements.

In terms of recent trends, King, San Diego, and Orange cited realignment toward outsourcing services because of a lack of internal funding, and because of the higher costs of providing programs using County employees. In this outsourced model, the counties retain policy formulation, program oversight, and program evaluation roles, while a network of community-based providers provide direct client services including inpatient and outpatient services.

We have provided a program overview for each of the comparison counties, as summarized in the following paragraphs. In addition, Appendix A lists additional responses from these counties, including cost determination, provider rate verification, rate adjustment procedures, year-to-year changes, and tracking systems.

King County, Washington

King County's Mental Health, Chemical Abuse and Dependency Services Division provides a range of substance abuse and chemical dependency services through 43 providers, who provide services for single or multiple modalities throughout the County. The King County program had a budget of more than $40 million in FY 2009-10 and serves more than 10,000 clients annually. At one time, the County provided intake assessment, residential services, and detoxification services directly, but over the last ten years has outsourced services to local licensed providers. The County now only retains a small in-house emergency response substance abuse treatment unit and program management staff.

Orange County, California

Orange County Alcohol and Drug Abuse Services (ADAS) provides substance abuse services through a combination of County run and staffed clinics, and through a network of local providers. The County now operates three clinics, although it used to operate seven until recently, and has 22 providers throughout the County. In FY 2009-10, the County treated more than 15,000 clients. County clinics provide the majority of outpatient services, while providers deliver some outpatient, residential, and detoxification services.

San Diego County, California

San Diego County Alcohol and Drug Services provides substance abuse services almost exclusively through a provider network and, for one program, utilizes state of California staff to provide direct client services. County staff provide oversight, administration, and program evaluation, and are also involved in drug court programs. However, the County outsources the majority of inpatient and outpatient programs to a network or providers. The County's substance abuse program had a budget of approximately $43 million in FY 2009-10 and served approximately 14,000 clients. The County's 50 providers, the majority of which are nonprofit, are located throughout the county and provide a full range of substance abuse modalities.

Riverside County, California

Riverside County provides the majority of its outpatient substance abuse services through seven county-operated clinics, while 20 providers offer inpatient and residential services to clients countywide. The relatively high number of providers is due in part to the county's large size and dispersed population base on its eastern side. In FY 2009-10, the county's budget was $29 million.

Counties Use Varied Approaches to Determine Costs

The counties and states we interviewed use varied approaches to determining costs in their FFS models. Market competition costing approaches were by far the most prevalent, which is in part due to historical precedent, county purchasing policies, and conditions that some federal agencies stipulate in funding agreements with the states or counties. Only one entity who we spoke with (Florida) funded and operated programs using a single approach to determining local provider costs.

We found that the terminology to describe cost approaches varied among all counties and states, making discussion and comparison difficult. To increase the validity of our data collection and to clarify each county's or state's costing approach, we defined five common costing approaches to determining service costs in substance abuse FFS models that we derived from initial interviews and our research. We discussed each of these approaches during our interviews with counties and states to determine which ones they employ. The following paragraphs describe the five approaches. In our descriptions, we use the term "funder" to describe the entity (state, county, or city) that oversees the program funds.

1. **Benchmarking**. The funder determines acceptable rates based on other payment guides such as, Federal Medicare, California's Drug Medi-Cal, Illinois's Division of Alcoholism and Substance Abuse Rate Guide, or rate guides from nearby counties. The funder either applies the guides' rates, or uses a guide as a basis to increase or decrease costs based on local conditions such as staff, facilities, or transport costs. For instance, King County uses the Washington State rates as a guide and adjusts fees upward by approximately 20% to take into account the high cost of living and staff salaries in the county. Conversely, a rural city or county might reduce its reimbursement rates to account for reduced facilities and staffing costs in rural areas.
2. **Historical Precedence**. Funders use cost data from their actual existing programs to forecast future rates by particular modality. For instance, if a funder paid a provider $100 for a

residential bed in 2010 and the provider reported no significant cost increases (and the local Consumer Price Index figures [CPI] remains unchanged), then the funder may choose to use the same cost for 2011. In another example, if the funder reviews actual cost data for a provider and notes that provider costs have increased 3 percent on average for past three years and these increases correlate to CPI changes, then it may increase provider service costs by 3 percent or more for the subsequent year.

3. **Market Competition**. Funders issue a Request for Proposal (RFP) as a means to solicit providers' offers to deliver substance abuse services. The RFP may be structured under one or more of the following formats:

   a. **Specified Service Cost RFP**: The funder specifies the cost of each modality or an acceptable cost range for each modality. Providers submit proposals and the funder reviews proposals and selects providers primarily based on experience, modalities served, geographic coverage, quality of service, and effectiveness of treatment—rather than focusing on cost.

   b. **Ceiling Cost RFP**: The funder specifies a maximum "not to exceed cost" per modality, and allows providers to submit reduced rates in their proposals to increase their competiveness. The funder then reviews the provider's maximum cost per modality, in comparison to other providers that responded to the RFP, and considers cost as a factor in awarding the RFP. For example, a funder may specify that a group counseling session cannot cost more than $15 per client. The funder may specify program scope by number of services required, or by specifying the total RFP amount.

   c. **Open Cost RFP**: The funder does not specify any cost restrictions, but limits the RFP's scope by volume of services, time span, or total cost. Providers develop their own costs, and respond to the funder's solicitation according to the scope of services. For example, a funder's RFP may result in three different responses for the cost of a ten-minute individual counseling session. The funder selects one or more providers that represent the best value to the funder based on a number of selection criteria, which typically include cost, quality, experience, and geographic coverage.

4. **Provider Cost Review**. The funder or a third party uses structured accounting tools to review the accounts of single or multiple providers, and determines costs for each service modality for a specific time period—normally one year. The funder or third party uploads detailed provider accounts into a database, and uses a series of algorithms to determine costs for each modality. This approach identifies costs, but does not directly identify employee time use or productivity, and it does not identify workload variances between employees. Examples of these types of tools include the Substance Abuse Treatment Cost Allocation and Analysis Template (SATCAP) and the Cost Reporting for Substance Abuse Treatment (CSAT).

5. **Provider Operational and Resource Review**. This approach is similar to the use of a time-and-motion study in that it requires a detailed analysis of individual staff activities in set increments, and matches this to resource costs to determine actual treatment costs. The funder or a third party administers a series of provider surveys and later conducts provider verification interviews to match individual staff workload to client caseload by modality to determine staff labor

associated with each service. The funder or third party then determines the cost of this labor, based on the provider's employee costs and productivity. The approach also measures employee productivity, and identifies any productivity variances between employees. Lastly, the funder or third party accounts for other costs such as facilities, information technology, and administration and allocates these costs across all modalities. This approach tends to be complex, and requires significant time commitment from providers and the funder. The approach also requires the funder or third party to undertake significant data compilation and analysis to determine actual costs.

Examples of this approach include the Substance Abuse Services Cost Analysis Program (SASCAP and the Drug Abuse Treatment Cost Analysis Program (DATCAP).

The SASCAP, by Research Triangle Institute (RTI) International, uses two large surveys—one focusing on direct and indirect labor costs—and the other on direct, indirect, and administrative costs and revenues. The DATCAP consists of a single 13-page survey that solicits information concerning personnel, contracted services, building and facilities, equipment, supplies and materials, and other resources. Trained staff then analyze the data to determine the apportionment of administrative overhead and the cost for each service modality.

Strengths and Weaknesses of Costing Approaches

The following paragraphs identify key strengths and weaknesses of the four costing approaches that we found in use with the counties and states interviewed as part of our review. The provider cost review approach was not specifically used by those entities we interviewed. Where applicable, we also note results of our research for specific costing approaches.

Benchmarking

Strengths

As identified from our research and interviews with San Diego, Orange, and Riverside, benchmark rates allow funders to compare providers based on their costs relative to a benchmark rate, which allows funders to make an initial cost determination. Funders can use this information to rank, or even disqualify vendors, if they feel that a provider's rates are too far from the benchmark rate. For instance, Orange informed us that it did not fund certain providers, with a key reason being that the provider's costs were significantly higher than the Drug Medi-Cal rate.

As identified from our research and interviews with San Diego and Riverside, benchmarking rates allow providers to plan ahead for what they will likely receive over the course of the program, allowing them the opportunity to forecast their resources and undertake their own fundraising. For example, if a provider knows that the funder will pay them according to the published Drug Medi-Cal rate and these rates are known to be relatively static, providers can plan their programs and seek private funds to meet their program costs.

Weaknesses

King, Orange, San Diego, Riverside, Miami-Dade, and Illinois all share the same belief that most benchmark rates published by state or federal departments do not cover the full cost for service for some modalities. They base this opinion from ongoing contact and negotiation with providers and through reviewing provider accounts that, in some instances, show a funding shortfall that the providers make up through their own fundraising.

Orange and San Diego found that benchmark rates do not adequately take into account the cost for provision of service in some locations, such as in areas where facilities costs are high. For instance, San Diego found that facilities rental rates vary by up to 100 percent depending on where a facility is located in the county.

King and Miami found that it is difficult to compare local services to benchmark rates because of differences in local populations and unanticipated local costs. Our research corroborated these perspectives. Miami cited an example of a local population, which includes a large disadvantaged minority population that has a significantly higher incidence of substance abuse than the rest of the county. King and Riverside counties also cited examples of rural and semi-rural areas where client transportation can be costly, and in some cases higher than the cost of service.

Historical Precedence

Strengths

King, Orange, San Diego, Riverside, and Illinois believe that a historical-based costing approach was useful because it allowed them to be able to project provider costs and determine their own budgets, and as funder budgets started to decrease in recent years, forecast the volume of services that would be lost.

King, San Diego, Orange and Riverside found that reviewing historical cost data also results in maintaining a closer and ongoing relationship with providers. As part of their program reviews, audits, and evaluations, the counties met with their providers and discussed program implementation, operations, and the appropriateness of resourcing. For example, King's providers informed them that legislation requiring increased staff certification had an increased cost that the County was not covering. San Diego found that having ongoing discussions on costs has increased its understanding of some of the constraints that its providers face, such as finding low cost facilities, when local resident concerns and city zoning ordinances reduce access to alternative sites.

Weaknesses

Illinois and King found that historical cost data formats, services, and standards can vary between funders, making valid comparisons difficult. For instance, Illinois cited a varying service standard, where the number of clients in group counseling varies considerably between providers, certain counties, and certain states. Furthermore, service definitions varied between the same entity; for example, a group counseling session is typically defined as either 50 minutes or one hour, although the distinction is not always specified in data reports.

San Diego, Riverside, and Orange report allowing higher payment rates for the same service from the same provider under different funding streams. Funders may employ this approach in part to compensate a provider for working in a socially difficult or geographically remote area, to assist the provider if they are renting a facility rather than the provider owning it, or to allow providers resources that they can use for staff development. However, the consequence would be that if new staff were to review the historical records without context and choose to pay the same or similar levels to other providers, they might be overpaying certain providers.

Market Competition

Strengths

King, Orange, San Diego, and Illinois stated that a market-based approach using the RFP process to solicit offers from providers allowed non-profits and for-profit organizations to compete in an open and fair environment. Most of these funders worked with non-profits, but use for-profit providers for some modalities.

Illinois noted that the RFP and any subsequent provider contract would need to specify in detail what services and performance standards should be for a particular modality because some organizations may try to reduce their labor and still service the modality. For instance, if two providers are paid the same amount for a one-hour session of group counseling for 100 clients, with provider A using ten counselors and provider B using two counselors, then provider B utilizes fewer resources for the same level of service. In addition, provider B's level of interaction between clients and staff may be questioned because it may not meet an appropriate level of service.

San Diego and King noted that market competition allows providers, typically non-profits that fundraise or deliver in-kind gifts, a cost advantage. For example, if a provider is able to offset its facilities costs using privately raised funds, the provider can lower its cost of service, and increase its competitive advantage.

Riverside, King, San Diego, and Orange valued the ability of the RFP to "pre-qualify" providers by assessing the providers against experience, quality, or cost standards noted in the RFP. For example, King stipulates required staff credentials in some RFPs, and uses this as a prequalification stage, allowing it to discard some provider offers and spend more time in negotiation with better qualified and more experienced vendors.

Riverside and San Diego found that using a Specified Service Cost RFP allowed providers more flexibility to account for their varied costs for each modality, and for their internal staffing and facilities cost differences. For example, a multi-site provider may offer 2,000 residential bed days for the funder's fixed amount and accept losses in one location if it can offset that cost from another less expensive location.

Weaknesses

Illinois described situations where providers that submitted lower rates in response to an RFP were subsequently unable to deliver services at an appropriate standard.

Orange described a situation where some providers' costs were so low and not offset by matching funds that the county was unsure if the provider could offer the quality of service required, and as such, did not fund them.

As identified from our research and from interviews with San Diego and Orange, when cost is the primary criteria for awarding a contract, some funders do not adequately consider providers' experience, capability, staff quality, and location. This may lead to instances where high-quality providers that have a history of solid outcomes are not selected because they are seen as too expensive in comparison to low-cost providers.

Orange and San Diego cited relatively static markets because there are relatively few providers in their counties, and there have been few changes in the provider market for some time. Consequently, market competition may not be that strong, resulting in some providers potentially taking advantage of the situation to increase their rates to an unreasonable level.

Provider Operational and Resource Review

Florida was the only entity that we interviewed that uses this type of costing approach.

Strengths

Florida stated that the approach accounted for all cost drivers, allowed for cost differences between providers, compensated providers for their actual costs, and set realistic cost limits for all programs.

Weaknesses

Some small providers find the system complex and it takes some time after registering with the state before they bid on local RFPs to provide substance abuse services.

Cost Drivers

All of the interviewees listed direct and indirect staffing costs as the primary cost driver pertaining to their programs or their providers' programs. King, San Diego, and Illinois noted that benchmark rates have not kept pace with the costs for credentialed and experienced staff, or the general increase in staffing costs over the last five-to-ten years. King and Illinois noted that increased health care costs have already adversely affected the ability of some providers to hire and retain quality staff.

All counties shared the common notion that the second largest cost driver for substance abuse programs are facilities costs, which can vary significantly throughout a county. San Diego, Orange, and Riverside pay varying rates to certain providers due to the variable cost of facilities in their counties. San Diego and Orange noted that some providers do not own their facilities, which adds significantly to provider costs.

Strengths and Weaknesses of the FFS Model

From our interviews with six counties and two states, there was both praise and criticism for the FFS model as referenced in the following strengths and weaknesses.

Strengths

San Diego and Orange stated that administrative time and associated costs pertaining to the use of the FFS model were relatively low because the model was well established, and counties and states had detailed client tracking and accounting systems in place.

Illinois and San Diego stated that small providers were better able to cope with a FFS model because there were typically fewer and less complex reporting requirements when compared to a performance-based or managed-care system.

Florida stated that so long as funders consider staffing as a major cost, and have the flexibility to accept higher rates and not the "lowest responsive bid," they can use the FFS rates to manage quality in their programs. For example, higher costs are typically reflective of higher staff salaries and staff with greater experience, who tend to produce better client outcomes.

Weaknesses

King stated that the FFS model does not allow sufficient flexibility for a provider to provide managed care for a client, because costs rapidly increase with the number of services, even though services may be conducted in the same session and may not be reflective of the actual provider costs. King also stated that the FFS model is too focused on treatment or service, rather than client outcomes.

Illinois stated that the FFS model, especially in situations where counties reviewed rates infrequently, did not allow smaller providers to adequately recover all costs and respond to rapid changes in overhead costs. Smaller providers are typically less able to absorb overhead price increases because they lack significant private funding or other public funding sources that they can use to mitigate losses incurred in delivering substance abuse programs.

San Diego, King, and Orange stated that their existing FFS model and associated policies, procedures, and systems may not be adequate if they were to adopt performance-based healthcare systems. They cited the potential need to substantially change their associated policies, procedures, and systems and questioned their ability to cover these increased administrative costs.

Florida stated that the FFS model does present some challenges for programs that are more focused on quality or outcomes because the FFS model has little incentive to motivate providers to produce sound outcomes.

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SECTION V-STANDARDIZED SERVICE DEFINITIONS

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1: INTRODUCTION

This section of the Rate Study details the current service modalities and then maps them to a recommended standard service definition that SAPC can use in the future, that aligns with other recommendations resulting from the Rate Study. The standard service definitions will play an integral role in the rate development process, as these will become the means by which providers will be able to provide and be paid for services to SAPC clients.

To prepare this section of the rate study, the MGT team conducted a thorough review of the existing service modalities and developed standard service definitions that correspond to the HCPCS and state service codes. The HCPCS codes used by the MGT team are H codes, S codes, and T codes. The purposes of these types of codes are as follows:

- H codes are used by state Medicaid agencies that are mandated by state law to establish separate codes for identifying mental health services such as alcohol and drug treatment services.
- The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. These codes are also used by the Medicaid program.
- The T codes are designated for use by Medicaid state agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need.[4]

In addition to the H, S, and T codes, the MGT team proposed the use of X codes where no applicable code type exists.

The MGT team worked closely with SAPC and providers to understand the current definitions, and then standardized the definitions across all service modalities. Specifically, the MGT team engaged in the following work steps:

Step 1: Examine Current Definitions:

The MGT team reviewed SAPC's 17 adult outpatient and residential substance abuse service modality definitions to get a broad understanding of the service delivery system and the kinds of services provided by the providers. The MGT team then identified applicable state service and HCPCS codes that correspond to the SAPC service definitions. From this analysis, the MGT team was able to identify standard codes that correspond to HCPCS codes. The crosswalk for each modality to HCPCS codes can be found in the following section.

[4] Centers for Medicare and Medicaid Services. "Healthcare Common Procedure Coding System (HCPCS) Level Ii Coding Procedures." Accessed 16 May 2011. <https://www.cms.gov/MedHCPCSGenInfo/Downloads/LevelIICodingProcedures.pdf>

Step 2: Conduct Stakeholder Interviews:

The MGT team conducted focus groups in December 2010 with over 30 providers to discuss the current modality service structure, and how services are provided under this model. From these focus groups, the MGT team was able to gather information and feedback on the current services provided and the understanding of SAPC's definitions and services. This included information gathering on the feasibility of providers to track, account for, and bill for services at a more discrete level of detail for the purposes of unbundling specific service modalities.

Step 3: Develop Standardized Definitions:

From there, the MGT team developed the standardized service definitions identified in this section of the rate study. The definitions are designed to provide SAPC staff, and eventually providers, with a coding structure that is more in line with the HCPCS codes and will help guide the future rates that the MGT team will set during the remainder of the Rate Study.

Below, the MGT team presents our analysis of the current service modality definitions (Section 2: Current Service Modalities), and recommends standard service definitions (Section 3: Recommended Service Definitions).

2: CURRENT SERVICE MODALITIES

The following section details the current SAPC service modality definitions for each of the 17 adult outpatient and residential substance abuse service modalities included in the Rate Study. This section also identifies the current state service code that corresponds to the SAPC modality, and identifies a corresponding HCPCS code that is most relevant to the services provided within each modality, as currently defined. Additional service codes were included for certain modalities based on data received during the December 2010 provider focus groups. Section 3: Recommended Service Definitions details the complete working definition for each code as defined by the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

2.1 Alcohol and Drug-Free Housing

Current SAPC Definition:

Transitional housing that is exempt from licensing in facilities that provide affordable, safe, and supported living environments for no more than six individuals who are recovering from substance use. The presence or use of alcohol or other drugs is prohibited. No treatment services are provided.

State Service Code: 57

Housing centers help recovering patients to maintain an alcohol- and drug-free lifestyle. Residents are free to organize and participate in self-help meetings or any activity that helps to maintain sobriety. The house/residents cannot provide treatment, recovery, or detoxification services; do not have treatment

or recovery plans or maintain resident files; and do not have structured or scheduled programs of alcohol and drug education, counseling, or recovery support sessions.

Associated HCPCS Codes:

Code	Definition
S9976	Lodging-Lodging, per diem, not otherwise specified
H0003	Laboratory Analysis-Alcohol and/or drug screening-laboratory analysis of specimens
H0048	Alcohol and/or other drug testing-Collection/handling only, other than blood

2.2 Case Management

Current SAPC Definition:

Case management is a participant-centered, goal-oriented service that includes assessment of participant needs for particular services; assisting the participant in obtaining services; and reviewing participant accomplishments, outcomes, and barriers. Activities are designed to integrate, coordinate, and access and engage necessary services to ensure successful treatment.

State Service Code: 68

Case management services are activities involved in the integrating and coordinating of all necessary services to ensure successful treatment and recovery. Services may include outreach, intake, assessment, individual service plans, monitoring and evaluation of progress, and community resource referrals.

Associated HCPCS Codes:

Code	Definition
H0006	Case Management-Alcohol and/or drug services; case management

2.3 Community Assessment and Service Center Program

Current SAPC Definition:

Program provides an assessment of a participant's substance use and mental health disorders using a standardized and computerized substance abuse and mental health assessment tool. Based on the assessment results, referrals are made to the appropriate substance abuse and mental health outpatient, residential, or ancillary services; outreach to service providers and County residents; and maintenance of collaborative linkages with other resources to support increased access to a comprehensive range of specific services needed by each program participant.

State Service Code: N/A

Associated HCPCS Codes:

Code	Definition
H0001	Assessment-Alcohol and/or drug assessment-evaluation by a clinician

2.4 Day Care Rehabilitative

Current SAPC Definition:

Outpatient and rehabilitation services provided at least three hours per day, three days per week to persons with substance abuse diagnoses; who are pregnant or in the postpartum period per Drug Medi-Cal (DMC); and/or the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized.

State Service Code: 30

Day care rehabilitative (DCR) services duration of three or more hours, but less than 24 hours per day for three or more days per week. DMC-certified programs provide outpatient counseling and rehabilitation services at least three hours per day, three days per week, but less than 24 hours per day.

Associated HCPCS Codes:

Code	Definition
H0015	Day Care Habilitative Treatment-Alcohol and/or drug services; intensive outpatient (three hours per day, three days per week with a maximum of 19 hours)
H0003	Laboratory Analysis-Alcohol and/or drug screening-laboratory analysis of specimens
H0048	Alcohol and/or other drug testing-Collection/handling only, other than blood

2.5 HIV Early Intervention Services

Current SAPC Definition: N/A

State Service Code: 65

Services include activities involved in the prevention and delay of the progression of HIV by encouraging HIV counseling, testing, assessment of disease progression, and provision of prophylactic and anti-viral prescription drugs

Associated HCPCS Codes:

Code	Definition
H0022	Intervention Services-Alcohol and/or drug services: Intervention Services (Early Intervention)

2.6 Outpatient Drug Free Individual Counseling

Current SAPC Definition:

Services are bundled and include screening, assessment, development of treatment plans, individual and group counseling, urinalysis testing, and vocational or other educational activities for adults. Services may be provided for co-occurring individuals whose primary problem is substance abuse with mental health as a secondary condition. Individual counseling consists of 50-minute face-to-face visits and group counseling is a 90-minute session for a minimum of 2 times per week.

State Service Code: 34

Services are provided to clients who do not live in the facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and/or supportive services. The DMC beneficiaries receive individual counseling, which is face-to-face contact between a client and a therapist or counselor. Services are limited to intake, evaluation, assessment and diagnosis, treatment and discharge planning, collateral services, and crisis intervention.

Associated HCPCS Codes:

Code	Definition
H0049	Alcohol and/or Drug Screening-Process designed to identify an individual who has an alcohol and/or drug use problem
H0001	Assessment-Alcohol and/or drug assessment-The evaluation of an individual by a clinician
T1007	Treatment Plan Development/Modification-Alcohol and/or substance abuse services, treatment plan development and/or modification
H0004	Individual Counseling-Behavioral health counseling and therapy, per 15-minute segment
H0003	Laboratory Analysis-Alcohol and/or drug screening-laboratory analysis of specimens
H0048	Alcohol and/or other drug testing-Collection/handling only, other than blood
T1012	Skills Development-Alcohol and/or substance abuse services, skills development

2.7 Outpatient Drug-Free Group Counseling

Current SAPC Definition:

Services are bundled and include screening, assessment, development of treatment plans, individual and group counseling, urinalysis testing, and vocational or other educational activities for adults. Services may be provided for co-occurring individuals whose primary problem is substance abuse with mental health as a secondary condition. Individual counseling consists of 50-minute face-to-face visits and group counseling in a 90-minute session for a minimum of two times per week.

State Service Code: 33

Services are provided to clients who do not live in the facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and/or supportive services. The DMC beneficiaries receive two group counseling sessions at 90-minute per group, per 30-day period depending on his/her needs and treatment plan or be subject to discharge. One or more counselors treat four or more clients, and up to ten clients focusing on the needs of individual served.

Associated HCPCS Codes:

Code	Definition
H0049	Alcohol and/or Drug Screening-Process designed to identify an individual who has an alcohol and/or drug use problem
H0001	Assessment-Alcohol and/or drug assessment-The evaluation of an individual by a clinician
T1007	Treatment Plan Development/Modification-Alcohol and/or substance abuse services, and treatment plan development and/or modification
H0005	Group Counseling-Alcohol and/or drug services; group counseling by a clinician
H0003	Laboratory Analysis-Alcohol and/or drug screening-laboratory analysis of specimens
H0048	Alcohol and/or other drug testing-Collection/handling only, other than blood
T1012	Skills Development-Alcohol and/or substance abuse services, skills development

2.8 Outpatient Drug Court Treatment and Recovery Services

Current SAPC Definition:

Outpatient programs for adults provide a comprehensive and integrated program of treatment and rehabilitation services, which are consistent with accepted Los Angeles County Drug Court standards and practices. Bundled services include individual and group counseling, crisis intervention, self-help groups, urinalysis testing, and referral to ancillary services.

State Service Code: N/A

Associated HCPCS Codes:

Code	Definition
H0015, H9	Alcohol and/or drug services; intensive outpatient (three hours per day, three days per week, with a maximum of 19 hours)
H0003, H9	Laboratory Analysis-Alcohol and/or drug screening; laboratory analysis of specimens
H0048, H9	Alcohol and/or other drug testing-Collection/handling only, other than blood
T1012	Skills Development-Alcohol and/or substance abuse services, skills development

Additional Notes:

The Drug Court Modality requires additional, bundled non-medical services that are not covered by HCPCS coding. These services include, but are not limited to: transportation to court appointments, provider travel for on-site assessments, and coordination with court officials.

2.9 Outpatient Narcotic Treatment Program (all types)

Current SAPC Definition:

Publicly funded programs administer methadone accompanied by ancillary medical and social services for individuals 18 years of age or older with a history of two or more failures in alternative treatment programs.

State Service Code: 48

The service element is comprised of the provision of methadone as prescribed by a physician to alleviate the symptoms of withdrawal from narcotics, and other required/appropriate services and activities provided in compliance with California Code of Regulation Title 9, Chapter 4, beginning Section 1000. Bundled services include intake, assessment and diagnosis, all medical supervision, urine drug screening, individual and group counseling, admission physical examinations, laboratory tests (Title 9 and 22), individual counseling (face to face contacts with therapist or counselor), and group counseling (two or more clients at once). For DMC, groups must have a minimum of four and maximum of ten persons (Title 22, June 1, 2001).

Associated HCPCS Codes:

Code	Definition
H0003	Laboratory Analysis-Alcohol and/or drug screening; laboratory analysis of specimens
H0049	Alcohol and/or Drug Screening-Process designed to identify an individual who has an alcohol and/or drug use problem
H0001	Assessment-Alcohol and/or drug assessment-The evaluation of an individual by a clinician
H0020, HG	Methadone Administration-Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
99203/99204/ 99205	Physical Evaluation/Exam-Physical evaluation/exam (30, 45, or 60 minutes) of a patient by a physician, face-to-face
H0004	Individual Counseling-Behavioral health counseling and therapy, per 15-minute segment
H0005	Group Counseling-Alcohol and/or drug services; group counseling by a clinician
H0016	Medical Intervention in an Ambulatory Setting-Alcohol and/or drug services; medical/somatic

2.10 Outpatient Narcotic Treatment Program (methadone detoxification)

Current SAPC Definition:

Publicly funded programs administer methadone in decreasing doses for a period not to exceed 21 days to assist an individual's withdrawal from dependency on heroin or other morphine-like drugs.

State Service Code: 41

Provision of narcotic withdrawal treatment pursuant to California Code of Regulations Title 9, Section 1000, to clients who with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence.

Associated HCPCS Codes:

Code	Definition
H0020, HG	Methadone Administration-Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)

2.11 Residential

Current SAPC Definition:

Residential is a 24-hour program within a licensed facility for adults 18 years of age or older. Bundled services may include intake, assessment, screening, individual and group counseling, crisis intervention, self-help groups, social and recreational activities, and urinalysis testing. These services may be provided for co-occurring individuals whose primary issue is substance abuse with mental illness as a secondary disorder.

State Service Code: N/A

The DMC residential is only for pregnant and post-partum women who are DMC beneficiaries. The post-partum period is a 60-day period beginning on the last day of pregnancy. The licensed treatment capacity for DMC perinatal certification cannot be more than 16 persons. Beds occupied by children are not counted toward the 16-bed limit.

Associated HCPCS Codes:

Code	Definition
H0017	Residential Treatment Program-Behavioral health; residential (hospital residential treatment program), without room and board, per diem
X9999	Residential Room and Board-Room and board, per diem, residential

The recommended HCPCS codes for residential services represent an unbundling of residential services, since there will be two separate codes billed for the same day of residential services—one code for treatment and one code for room and board.

A bundled rate is one that wraps the cost for all aspects of treatment into a single rate. It expects that therapeutic interventions will occur every day throughout the day, though in varying amounts. The bundling of the rate allows program staff to spend the needed amount of time with a particular patient working on a particular issue on any given day, without the undue burden of relegating that activity to specified time-limited blocks with accompanying arbitrary limits on the number of service units that can be provided.

However, since it can be considered to be more difficult to monitor compliance with the delivery of a service package than it is to verify the provision of a discrete service on a particular date, the federal government has begun to increase restrictions on bundled rates in a variety of service settings.
The MGT team considers the separation of treatment and room and board rates as a first step. Once more discrete service-level data is being reported to SAPC on the cost reports, it will make sense that the treatment rate for residential services is actually unbundled and providers will be required to bill separately for each service that is being provided. However, this is a long-term consideration that will require further analysis and understanding of the services being provided in the residential setting.

2.12 Residential/Recovery Short Term (up to 30 days)

Current SAPC Definition: N/A

State Service Code: 52

Short-term residential care is typically 30 days or less of non-acute care in a setting with recovery/ treatment services for alcohol and other drug abuse and dependency. Bundled services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, and detoxification services, and may include assistance in obtaining health, social, vocational, and other community services.

Associated HCPCS Codes:

Code	Definition
H0018	Residential Treatment Program-Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem, less than 30 days
X9999	Residential Room and Board-Room and Board, per diem, residential

2.13 Residential/Recovery Long Term (over 30 days)

Current SAPC Definition: N/A

State Service Code: 51
Long-term residential is typically over 30 days of non-acute care in a setting with recovery/treatment services for alcohol and other drug use and dependency. Bundled services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, and detoxification services, and may include assistance in obtaining health, social, vocational, and other community services.

Associated HCPCS Codes:

Code	Definition
H0019	Residential Treatment Program-Behavioral health; long term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
X9999	Residential Room and Board-Room and board, per diem, residential

2.14 Residential Detoxification

Current SAPC Definition: N/A

State Service Code: 50

Free standing residential detoxification is defined as services in a non-hospital setting that provide for safe withdrawal and transition to ongoing treatment.

Associated HCPCS Codes:

Code	Definition
H0012	Sub-Acute Detoxification (Clinically Managed)-Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient, clinically managed)

Additional Notes:
H0012 was chosen based on a comparison of the SAPC definition and Focus Group data with current American Society of Addiction Medicine (ASAM) Level of Care Guidelines for detoxification programs. A complete standard of care analysis will be included in Section VI. Standards of Care.

2.15 Hospital Inpatient Detoxification

Current SAPC Definition:

Residential medical detoxification services are directed toward the care and treatment of persons suffering from the toxic effects of alcohol, narcotics, and other dangerous drugs. The services are conducted within a licensed facility. Services include physical examination and assessment of medical history within 24 hours of admission and includes drug screening (urinalysis). A physician in charge of the client should be on call 24-hours a day, 7 days a week. The physician visits client and documents client's progress at least every 48 hours. The contractor is required to employ appropriate standards of medical practice and the attending physician may require diagnostic testing and prescribe needed medications. Services include medications prescribed by physician, regular case conferences to monitor client progress, counseling, and aftercare.

State Service Code: 54

Hospital inpatient residential care is medical care (other than detoxification) in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency.

Associated HCPCS Codes:

Code	Definition
H0010	Sub-Acute Detoxification (Medically Monitored)-Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient, medically monitored)

Additional Notes:
H0010 was chosen based on a comparison of the SAPC definition with current ASAM Level of Care Guidelines for detoxification programs. While the Focus Group data indicated that certain providers were equipped to treat acute care cases, those providers also indicated that they were not licensed to do so. As such, the MGT team recommends the sub-acute, medically monitored HCPCS definition.

2.16 Satellite Housing Center

Current SAPC Definition:

The facility is exempt from licensing and provides safe, stable, alcohol and drug-free housing for pregnant women and their children while they participate in a perinatal treatment and recovery program. The center has six beds and the number of children will be determined by the contracted agency. No treatment services are provided.

State Service Code: N/A

Associated HCPCS Codes:

Code	Definition
S9976	Lodging-Lodging, per diem, not otherwise specified
H0003	Laboratory Analysis-Alcohol and/or drug screening; laboratory analysis
H0048	Alcohol and/or other drug testing-Collection and handling only, specimens other than blood

2.17 Training

Current SAPC Definition:

Training and technical assistance services are a broad range of activities to educate and instruct Los Angeles County-contracted providers on strategies to improve existing treatment, service delivery, and prevention/education services in the field of substance abuse. Services include assistance in the development of alcohol and drug programs and implementation of administrative systems consistent with Los Angeles County standards and procedures. Some program activities include consultation, organizational analysis and reviews, program evaluations, training, and workshops.

State Service Code: N/A

Associated HCPCS Codes:

The most common HCPCS code for training with regard to substance use disorders is used for those individuals who are not employed by a provider; for example: volunteers, family members of patients, etc. However, the current SAPC definition aligns with the information collected during the December 2010 Focus Groups.

3: RECOMMENDED SERVICE DEFINITIONS

The following includes the MGT team's recommended service definitions. The MGT team is recommending that SAPC move to a HCPCS coding structure for all providers and contracts in the future. Moving to an HCPCS structure will allow SAPC to be in a position to implement future health care reform mandates and align service delivery with implementation requirements from federal agencies such as the Centers for Medicare and Medicaid Services. The MGT team understands that moving to a HCPCS coding structure will not be easy and it will be met with resistance from providers; however, as part of the overall Rate Study recommendations, the MGT team will detail how to implement these changes with providers and the potential impacts on service delivery.

As detailed in Section IX. Barriers, Disincentives, and Recommendations, the MGT team believes that SAPC should certify providers as eligible to bill for specific procedure codes. That allows SAPC to maintain oversight by certifying only those providers that meet certain criteria, and it will allow SAPC to manage funding caps, or ceilings, for specific codes on a per-unit basis.

Below are the recommended service definitions organized by HCPCS definition. These definitions are based on the associated HCPCS codes from the service modalities identified in Section 2. In addition, these definitions include several codes that do not relate to the current SAPC service modalities, but are related to current or future SAPC pilot programs and services. These codes include brief interventions (H0050), Naltrexone, the generic name for Vivitrol (J2315), medical home program maintenance (S0281), wellness assessment (S5190), and smoking cessation treatment (S9075).

Healthcare Common Procedural Coding System Definitions

HCPCS Code	Working Definition[5]
H0001	Assessment-Alcohol and/or drug assessment. The evaluation of an individual by a clinician to determine the presence, nature, and extent of substance use disorder with the goal of formulating a plan for services (if such services are offered) and treating the client in the most appropriate treatment environment.
H0003	Laboratory Analysis-Alcohol and/or drug screening-laboratory analysis of specimens for presence of alcohol and/or drugs.
H0004	Individual Counseling-Behavioral health counseling and therapy (includes intake), per 15-minute segment–Utilization of special skills by a clinician, per 15-minute segment, to assist individuals and/or their families/significant others in achieving substance abuse or mental health treatment objectives. Substance abuse treatment objectives can be achieved through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making, and/or discussing didactic materials with regard to substance use disorders. Mental health treatment objectives can be achieved through the provision of counseling in any of its forms. It may be provided in a variety of sites, by a wide range of mental health professionals, and in different modes or formats for clients.
H0005	Group Counseling-Alcohol and/or drug services, group counseling by a clinician-means services provided by a clinician to assist two or more individuals and/or their families/ significant others to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and considering alternative solutions and decision making with regard to alcohol and other drug-related problems.
H0006	Case Management-Alcohol and/or drug services; case management-Services provided to link individuals to; or to assist and support clients in gaining access to; or to develop their skills for gaining access to needed medical, social, educational, and other services essential to meeting basic human needs, as appropriate; to train the individual in the use of basic community services; and to monitor treatment progress and overall service delivery.

Continued

[5] Expanded definitions sourced from: Substance Abuse and Behavioral Health Unofficial Standard Working Definitions HCPCS Code Guide. Prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) for the Center for Substance Abuse Treatment (CSAT). Updated August 29, 2007.

HCPCS Code	Working Definition[5]
H0010	Sub-Acute Detoxification (Medically Monitored)-Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient, medically monitored)-Face-to-face interactions with an individual for the purpose of medically managing and monitoring withdrawal symptoms from alcohol and/or drug addiction in a residential addiction program with appropriate accreditation, certification, and licensure. The program shall be staffed with a sufficient number of personnel on a 24-hour per day basis to meet the health care needs of the residents served by personnel trained, authorized, and credentialed (where applicable) to carry out assigned job responsibilities consistent with scopes of practice, resident population characteristics, and the resident's individual plan of care/treatment.
H0012	Sub-Acute Detoxification (Clinically Managed)-Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient, clinically managed)-means face-to-face interactions with an individual for the purpose of medically managing and monitoring withdrawal symptoms from alcohol and/or drug addiction as an outpatient through a residential addiction program with appropriate accreditation, certification, and licensure. The program shall be staffed with a sufficient number of personnel on a 24-hour per day basis to meet the health care needs of the residents served by personnel trained, authorized, and credentialed (where applicable) to carry out assigned job responsibilities consistent with scopes of practice, resident population characteristics and the resident's individual plan of care/treatment.
H0015	Day Care Habilitative Treatment-Alcohol and/or drug services; intensive outpatient (three hours per day, three days per week with a maximum of 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.
H0016	Medical Intervention in an Ambulatory Setting-Alcohol and/or drug services: medical/somatic means medical intervention including physical examinations and prescriptions or supervision of medication to address the physical health needs of the alcohol and other drug addiction clients served. Medical service means the same as medical somatic service. This service does not include detoxification, rehabilitation, methadone administration, or alcohol and other drug screening analysis.
H0017	Residential Treatment Program-Behavioral health; residential (hospital residential treatment program), without room and board, per diem-means 24-hour per day hospital facility (licensed by the State Hospital Authority) without room and board, and a level of care where a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for persons with substance use disorders or mental health disorders occurs. Length of stay is typically 30 days or less.

Continued

HCPCS Code	Working Definition[5]
H0018	Residential Treatment Program-Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem-means 24-hour per day non-acute care in a non-hospital, residential treatment program without room and board, and a level of care where a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for persons with substance use disorders or mental health disorders occurs. Length of stay is typically 30 days or less.
H0019	Residential Treatment Program-Behavioral health; long term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem-means 24-hour per day, non-medical, non-acute care in a residential treatment facility, without room and board that provides support, typically for more than 30 days for persons with substance use disorders or mental health disorders. A long-term residential facility may include quarter-way house, halfway house, and recovery home, transitional residential, secondary treatment, etc.
H0020, HG	Methadone Administration-Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).
H0022	Intervention Services-Alcohol and/or drug services: Intervention Services (Early Intervention), any planned intervention that may assist a person to abstain from AOD use.
H0048	Alcohol and/or other drug testing-Collection and handling only, specimens other than blood-including hair, saliva, urine, or other specimens for the purposes of analysis for the presence of alcohol and/or other drugs, and does not include the laboratory analysis of such specimens.
H0049	Alcohol and/or Drug Screening-Process designed to identify an individual who has an alcohol and/or drug use problem or is at risk for developing one by evaluating responses to questions about alcohol and/or other drug use. A valid brief questionnaire about the context, frequency, and amount of alcohol and/or other drug use can be used to examine substance use patterns. Examples of valid questionnaires are the AUDIT (Alcohol Use Disorder Identification Test), MAST (Michigan Alcohol Screening Test), DAST (Drug Abuse Screening Test), and ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). A positive screen results in a recommendation for a brief intervention for individuals with an alcohol and/or drug use problem or at risk of developing one, or a referral to a substance abuse treatment program for individuals with severe alcohol and/or other drug abuse and dependence.

Continued

HCPCS Code	Working Definition[5]
H0050	Brief Intervention-Alcohol and/or drug services, brief intervention, per 15-minute segment-a brief one-on-one session in which concerns about an individual's alcohol and/or other drug use are expressed. The intervention usually follows immediately after an individual receives a positive screen indicating that an alcohol and/or drug use problem is present or there is a risk for developing one. Feedback is given on alcohol and/or other drug use patterns. The intervention focuses on increasing motivation for behavior change to reduce harmful levels of alcohol/and or other drugs. Intervention strategies include education, simple advice, brief counseling, continued monitoring, or referral to a substance abuse treatment specialist.
J2315	Naltrexone-Injection, Naltrexone, depot form, 1 mg.
S0281	Medical Home Care Coordination Maintenance-Medical Home Program, comprehensive care coordination and planning, maintenance of plan-maintenance of cross-service care coordination. (This code is a placeholder in anticipation of health care reform. The code will only be used if necessary during future contract years. Further guidance on the use of this code will be given to providers prior to its implementation.)
S5190	Wellness Assessment-Wellness assessment, performed by non-physician.
S9075	Smoking Cessation Treatment-Smoking cessation treatment, per 15 minutes.
S9976	Lodging-Lodging, per diem, not otherwise specified.
T1007	Treatment Plan Development/Modification-Alcohol and/or substance abuse services, treatment plan development and/or modification-means design or modification of the treatment or service plan for substance use disorders. This may be the initial plan for a client beginning treatment or the modification of a plan for a client already in treatment. It is typically a scheduled service not necessarily delivered in conjunction with other treatment. This service may require the participation of clinicians and specialists in addition to those usually providing treatment.
T1012	Skills Development-Alcohol and/or substance abuse services, skills development-Activities to develop client community integration and independent living skills. Services may be provided in individual or group settings but not necessarily at scheduled events, and may be offered in the context of other normal activities, such as education or employment.
99203 99204 99205	Physical Evaluation/Exam-Physical evaluation/exam (30, 45, or 60 minutes) of a patient by a physician, face-to-face.
X9999	Residential Room and Board-Room and board, per diem, residential.
Modifiers	HH-Integrated Mental Health and Substance Abuse Services. HD-Pregnant/Parenting Women's Program. H9-Court Ordered.

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SECTION VI-STANDARDS OF CARE

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1: INTRODUCTION AND PURPOSE

As was described in Section V. Standardized Service Definitions of the Rate Study, the MGT team analyzed SAPC's 17 current adult outpatient service modalities and redefined them according to HCPCS terminology. To continue this process of refining and standardizing service delivery, with the goal of ensuring that the rates developed for SAPC represent the most appropriate standards of care, this section of the Rate Study details the standards of care for the defined services. To develop the standards of care, the MGT Team conducted a comprehensive review of state, federal, and clinical service guidelines. Our review included the following sources.

- Drug Medi-Cal Billing Manual
- Medicare Principles in the Provider Reimbursement Manual 15-1
- Medicaid State Plan Section 4.19
- California Code of Regulations
- Health and Safety Codes
- Code of Federal Regulations
- HCPCS data
- American Society for Addiction Medicine (ASAM) Guidelines and Placement Criteria
- Substance Abuse and Mental Health Services Administration (SAMHSA) Guidelines

The standards developed by the MGT team represent the minimum appropriate service level for SAPC-funded providers, and include service and staffing requirements, where applicable. These standards are intended to ensure that individuals receiving substance use disorder treatment under SAPC may receive a consistent and appropriate level of service at any Los Angeles County provider.

2: POPULATIONS SERVED

The population of individuals served consists of adult (18 years of age or older) substance users seeking drug and alcohol treatment services, including individuals identified as having co-occurring disorders or HIV/Acquired immune deficiency syndrome (AIDS), and regardless of age, ethnicity, national origin, race, religion, sexual orientation, gender identification, or physical or mental disability.

3: SERVICE STANDARDS

The following standards of care represent a combination of federal and state regulations and clinical practice guidelines. Associated staffing requirements and guidelines are also included where applicable.

The MGT team is aware that the State of California is currently assessing aspects of service delivery including service standards. While the MGT team has identified and detailed standards in this section of the Rate Study, this document will defer to any new state standards that may be issued during or after this study.

The standards identified below follow the order of the recommended service definitions as identified in Section V. Standardized Service Definitions of the Rate Study beginning with "3: Recommended Service Definitions."

3.1-H0001 Assessment[6,7]

HCPCS Definition
Alcohol and/or drug assessment: The evaluation of an individual by a clinician to determine the presence, nature, and extent of substance use disorder with the goal of formulating a plan for services (if such services are offered), and treating the client in the most appropriate treatment environment.

Standards of Care
The assessment must enable the provider to determine the most appropriate treatment placement and treatment plan. Assessments must use more than one source of clinical information, including, but not limited to: self-assessment instruments, clinical records, structured clinical interviews, collateral contacts with significant others and family members, and other assessment measures. By referencing multiple sources, the assessor should gain perspective regarding the client's history, level of functioning and impairment, and degree of distress.

The Addiction Severity Index (ASI) is the most widely used substance abuse assessment tool that collects information on seven domains: medical status, employment/support status, drug use, alcohol use, legal status, family/social relationships, and psychiatric status. While the use of ASI is not an absolute requirement, the assessment tool used must be a standardized tool with proven reliability and validity.

Reassessment must be performed if a relapse occurs that may require referral to a different or higher level of care.

Client Placement Criteria for Group Counseling

The ASAM PPC-2R treatment criteria must be used in determining client placement. The criteria consist of five levels of service:

- Level 0.5 Early Intervention
- Level I Outpatient Treatment
- Level II Intensive Outpatient Treatment/Partial Hospitalization
- Level III Residential/Inpatient Treatment
- Level IV Medically Managed Intensive Inpatient Treatment

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6 Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97-3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997.

7 State of California, Health and Human Services Agency, Department of Alcohol and Drug Programs. *Treatment Standards for Substance Use Disorders: A Guide for Services.* Spring 2010.

For placement in group therapy, provider3s must also consider the following:

- A client's stage of recovery
- The progression of the disease
- The client's stage of readiness for change

Staffing Standards
Assessments must be performed by qualified and trained clinicians who are registered, certified and/or licensed to practice in the state of California.

3.2-H0003 Laboratory Analysis[8]

HCPCS Definition
Alcohol and/or drug screening-Laboratory analysis of specimens for presence of alcohol and/or drugs.

Standards of Care
Laboratory analysis must conform to the federal guidelines for drug testing, as set forth by the Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Personnel performing laboratory analysis on collected specimens must follow established laboratory procedures to prevent contamination and ensure chain of custody.

Staffing Standards
Laboratory analysis is performed by a trained laboratory technician in a SAMHSA-certified laboratory setting.

3.3-H0004 Individual Counseling[9]

HCPCS Definition
Behavioral health counseling and therapy, per 15-minute segment: Utilization of special skills by a clinician, per 15-minute segment, to assist individuals and/or their families/significant others in achieving substance abuse or mental health treatment objectives. Substance abuse treatment objectives can be achieved through the exploration of alcohol and other drug problems and/or addiction and their ramifications, including an examination of attitudes and feelings, consideration of alternative solutions and decision making, and/or discussing didactic materials with regard to substance use disorders. Mental health treatment objectives can be achieved through the provision of counseling in any of its forms. It may be provided in a variety of sites, by a wide range of mental health professionals, and in different modes or formats for clients.

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8 HHS Mandatory Guidelines for Drug Testing: 75 FR 22809. Updated April 2010.

9 Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Standards of Care
Individual counseling is generally scheduled for four, 15-minute segments that includes 50 minutes of face-to-face direct service at least weekly, as part of a broader spectrum of substance use treatment services. However, the frequency and duration of sessions can vary significantly depending on the individual's stage of recovery and psychological state.

An individual counseling session frequently follows a standard format. A counselor may ask the client about reactions to the recent group meeting, explore how the client spent time since the last session, ask how the client is feeling, inquire about drug and alcohol use, and ask whether there are any urgent issues. The counselor helps the client review reactions to recent group topics, reviews treatment plans and coping strategies, addresses fears and anxieties related to the change process, provides personalized feedback on urine toxicology and Breathalyzer™ results, and probes into sensitive issues that are difficult to discuss in the group. Counselors also help clients to access services they need that are outside the treatment program's capabilities and plan the transition to another level of care or discharge.

Staffing Standards
Individual counseling sessions are provided by, at minimum, substance abuse counselors registered, certified, and/or licensed by an accredited, California Department of Alcohol and Drug Programs (ADP)-approved, certifying organization.

3.4-H0005 Group Counseling[10]

HCPCS Definition
Alcohol and/or drug services; group counseling by a clinician-services provided by a clinician to assist two or more individuals and/or their families/significant others to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and considering alternative solutions and decision making with regard to alcohol and other drug-related problems.

Standards of Care
Substance abuse counselors use a number of group treatment models to meet client needs. Five group therapy models that are considered effective in treating substance abuse are:

- Psychoeducational groups,
- Skills development groups,
- Cognitive–behavioral/problem solving groups,
- Support groups, and
- Interpersonal process groups.

[10] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Group counseling sessions are scheduled for 90 minutes, although shorter and longer time frames also are used depending on the group activities and goals. Psychoeducational group sessions often are only half that long (for example, a 30-minute lecture followed by 15 minutes for questions), because they focus on instruction instead of interaction.

Staffing Standards
Group counseling sessions are led by, at minimum, substance abuse counselors registered, certified, and/or licensed by an accredited, ADP-approved, certifying organization.

3.5-H0006 Case Management[11,12]

HCPCS Definition
Alcohol and/or drug services; case management: Services provided to link individuals to, or to assist and support clients in gaining access to or to develop their skills for gaining access to needed medical, social, educational, and other services essential to meeting basic human needs, as appropriate; to train the individual in the use of basic community services; and to monitor treatment progress and overall service delivery.

Standards of Care
Case Management refers to the planning and coordination of a package of health and social services that is individualized to meet a particular client's needs. While there are numerous accepted models for case management programs, eight generally accepted principles apply to the provision of case management for persons with substance use disorders.

1. Offers the client a single point of contact with the health and social services systems.
2. Is client-driven and driven by client need.
3. Involves advocacy.
4. Is community-based.
5. Is pragmatic.
6. Is anticipatory.
7. Must be flexible.
8. Is culturally sensitive.

Referrals represent one aspect of case management services within substance abuse treatment facilities. Such programs must perform the following functions:

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs.

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[11] Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

[12] Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

- Continuously assess and evaluate referral resources to determine their appropriateness.
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required.
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs.
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through.
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care.
- Evaluate the outcome of the referral.

Staffing Standards

While there are no generally accepted case management certification standards, case managers must possess an equally extensive breadth of knowledge and skill set as other substance abuse treatment specialists in order to provide optimal services to their clients. Case managers are not required to be registered with the state of California. Case managers who are registered may subsequently become certified and/or licensed to practice in the state. Additionally, case managers must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy.

The basic prerequisites of effective case management include the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in a dynamic client-case manager relationship, the willingness to be nonjudgmental toward clients, and certain "transdisciplinary foundations" created by the Addiction Technology Transfer Centers (ATTCs).

Examples of case manager competencies include:

- Understanding a variety of models and theories of addiction and other problems related to substance use.
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance abuse disorders.
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process.
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.
- Understanding the value of an interdisciplinary approach to addiction treatment.

3.6-H0010 Sub-Acute Detoxification (Medically Monitored)[13]

HCPCS Definition

Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient, medically monitored): Face-to-face interactions with an individual for the purpose of medically managing and monitoring withdrawal symptoms from alcohol and/or drug addiction in a residential addiction program with appropriate accreditation, certification, and licensure. The program shall be staffed with a sufficient number of personnel on a 24-hour, per-day basis to meet the health care needs of the residents served by personnel trained, authorized, and credentialed (where applicable) to carry out assigned job responsibilities consistent with scopes of practice, resident population characteristics, and the resident's individual plan of care/treatment.

Standards of Care

Substance abuse treatment providers serving patients whose detoxification symptoms are highly involved, but not classified as in need of acute care, fall under the ASAM Level III.7-D, Medically Monitored Inpatient Detoxification. Inpatient detoxification at this level of care provides 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Since this level of care is relatively more restrictive and more costly than the clinically managed residential treatment option (described in Section 4.7), treatment in this setting must be clearly focused and limited in scope. Primary emphasis must be placed on ensuring that the patient is medically stable; assessing for adequate biopsychosocial stability, quickly intervening to establish this adequately; and facilitating effective linkage to and engagement in other appropriate inpatient and outpatient services.

A physician must be available to assess the patient within 24 hours of admission (or sooner, if medically necessary), and must provide onsite monitoring and further evaluation on a daily basis. A nurse will be responsible for overseeing the monitoring of the patient's progress and medication administration on an hourly basis, if needed. Sub-acute facilities must have established procedures for securing acute-level care for patients whose needs, during the course of treatment, exceed the capabilities of the facility.

Staffing Standards

Inpatient detoxification programs employ registered, certified, and/or licensed clinicians (such as physicians, Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs), counselors, social workers, and psychologists), who provide a planned 24-hour program consisting of professionally directed evaluation, care, and treatment. An interdisciplinary team of appropriately trained clinicians must be available to assess and treat the patient and to obtain information regarding the patient's needs. The number and credentials of team members must be appropriate to the range and severity of the patient's problems. Additionally, appropriately licensed and credentialed staff must be available to administer medications in accordance with physician orders.

3.7-H0012 Sub-Acute Detoxification (Clinically Managed)[14]

[13] Center for Substance Abuse Treatment. *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

HCPCS Definition

Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient, clinically managed): Face-to-face interactions with an individual for the purpose of medically managing and monitoring withdrawal symptoms from alcohol and/or drug addiction as an outpatient through a residential addiction program with appropriate accreditation, certification, and licensure. The program shall be staffed with a sufficient number of personnel on a 24-hour, per-day basis to meet the health care needs of the residents served by personnel trained, authorized, and credentialed (where applicable) to carry out assigned job responsibilities consistent with scopes of practice, resident population characteristics, and the resident's individual plan of care/treatment.

Standards of Care

Residential detoxification programs provide 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Such programs that do not treat highly medically involved patients, as described in Section 4.6, are classified as ASAM Level III.2-D, Clinically Managed Residential Detoxification. These programs are characterized by an emphasis on peer and social support. Standards published by such groups as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide further information on quality measures for residential detoxification.

Facilities with lower levels of care must have established procedures for securing appropriate medical referral and linkage, especially in the case of emergencies (for example, danger of seizures, delirium tremens, or acute care symptoms that the facility is not capable of treating).

Staffing Standards

Residential detoxification programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for patient observation and supervision. Medical evaluation and consultation must be available 24 hours a day, in accordance with treatment/ transfer practice guidelines. All clinicians who assess and treat patients must be able to obtain and interpret information regarding the needs of these persons and must be knowledgeable about the biomedical and psychosocial dimensions of alcohol and other drug dependence. Such knowledge includes awareness of the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions, and how to facilitate the individual's entry into ongoing care. Staff must ensure that patients are taking medications according to their physician's orders and legal requirements.

[14] Center for Substance Abuse Treatment. *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

3.8-H0015 Day Care Habilitative Treatment[15]

HCPCS Definition
Alcohol and/or drug services; intensive outpatient (three hours per day, three days per week with a maximum of 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.

Standards of Care
The ASAM's definition of Day Care Habilitative treatment (DCH), also known as "rehabilitative," requires participants to have a minimum of nine hours of therapeutic contact per week—at least in the initial treatment stage. A typical DCH program provides outpatient counseling and rehabilitation services provided three hours of treatment per day, three days per week to persons with substance abuse disorders. The structure and services provided within the program may vary depending on the individual's needs. For example, the three days may entail two evenings of back-to-back, 90-minute groups (one for members in the same recovery stage to share day-to-day concerns and the other to study a psycho-educational topic). A third evening might include 30 minutes of individual counseling, a 90-minute family session, and an hour-long skills training group. Some DCH programs meet five days or evenings per week, although this level of care is not required to be classified as intensive outpatient care.

Staffing Standards
Counseling sessions provided as part of the intensive outpatient treatment program are led by, at minimum, registered, certified, and/or licensed substance abuse counselors.

3.9-H0016 Medical Intervention in an Ambulatory Setting[16]

HCPCS Definition
Alcohol and/or drug services—medical/somatic (medical intervention in ambulatory setting): means medical intervention including physical examinations and prescriptions or supervision of medication to address the physical health needs of the alcohol and other drug addiction clients served. Medical service means the same as medical somatic service. This service does not include detoxification, rehabilitation, methadone administration, or alcohol and other drug screening analysis.

Standards of Care
Medical intervention in an ambulatory setting is limited to once per day. This is most commonly not a stand-alone service and is provided in conjunction with ambulatory substance use treatment services.

[15] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

[16] Code of Federal Regulation Title 42 § 8.12: Federal opioid treatment standards

Staffing Standards

Services must be performed by qualified and trained clinicians who are registered, certified and/or licensed to practice in the state of California.

3.10-H0017 Residential Treatment Program-Short Term, Hospital, H0018 Residential Treatment Program-Short Term, Non-Hospital, H0019 Residential Treatment Program-Long Term, Non-Medical

HCPCS Definition

H00017-Behavioral health; residential (hospital residential treatment program), without room and board, per diem 24-hour per day hospital facility (licensed by the State Hospital Authority) without room and board, and a level of care where a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for persons with substance use disorders or mental health disorders occurs. Length of stay is typically 30 days or less.

H00018-Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem 24-hour per day non-acute care in a non-hospital, residential treatment program without room and board, and a level of care where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with substance use disorders or mental health disorders occurs. Length of stay is typically 30 days or less

H00019-Behavioral health; long term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem 24-hour per day, non-medical, non-acute care in a residential treatment facility, without room and board that provides support, typically for more than 30 days for persons with substance use disorders or mental health disorders. A long-term residential facility may include quarter-way house, halfway house, and recovery home, transitional residential, secondary treatment, etc.

Standards of Care

Residential Treatment Programs provide specialized treatment in a 24-hour setting for individuals with diagnosed substance use disorders. All services provided within the program are coordinated by an individualized treatment plan, and include services to improve the life skills of residents such that they can successfully re-enter the community. Individuals may be placed into short-term or long-term residential treatment and recovery programs based on their needs assessment and stage of recovery.

Staffing Standards

At minimum, residential treatment programs must include:

- A California licensed physician, or consulting licensed physician,
- A substance abuse counselor registered, certified, and/or licensed by an accredited, ADP-approved, certifying organization.
- And one of the following:
    - A California licensed psychologist and/or consulting licensed psychologist, or

- A California licensed mental health therapist and/or consulting licensed, mental health therapist.

Any unlicensed staff members working within the program must be supervised by a licensed professional.

3.11-H0020, HG Methadone Administration[17]

HCPCS Definition
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).

Standards of Care
The use of methadone for opioid detoxification is highly regulated, and the drug can only be prescribed for withdrawal by a licensed physician at a SAMHSA-certified methadone clinic or if the patient is being hospitalized for another medical condition. (Detoxification programs may become certified to prescribe methadone by undergoing the process described in the National Guideline Clearinghouse (NGC) summary of SAMHSA's TIP 43, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.)

Federal regulations allow for the use of methadone in both a short-term detoxification treatment of less than 30 days and a long-term maintenance treatment of 30 days or longer. The regulations also specify that if a patient has failed two detoxification attempts in a 12-month period he or she must be evaluated for a different course of treatment.

Once the dose requirement for methadone has been established, methadone can be given once daily and generally tapered over three-to-five days in 5-to-10 mg daily reductions. The initial dose requirement is determined by estimating the amount of opioid use and gauging the patient's response to administered methadone. Clinicians must perform a physical examination before determining the initial dosing requirement. Avoidance of overmedicating is crucial during methadone detoxification because excessive doses of this agent can produce overdose, whereas opioid withdrawal does not constitute a medical danger in otherwise healthy adults.

Patients with significant opioid dependence may require a starting dose of 30-to-40 mg per day; this dose range should be adequate for the most severe withdrawal. If the degree of dependence is unclear, withdrawal signs and symptoms can be reassessed one-to-two hours after giving a dose of 10 mg of methadone. Sedation or intoxication signs after a methadone challenge dose indicate a lower starting dose. Similarly, intoxication at any point of the detoxification signals the need to hold or more rapidly wean (reduce to a zero dose) the methadone. Care must be taken to avoid giving methadone to newly admitted patients with signs of opioid intoxication, since overdose could result. Methadone stabilization is the optimum treatment for patients who are pregnant and opioid dependent.

[17] Center for Substance Abuse Treatment. *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Staffing Standards
Staff administering methadone to patients must be licensed to do so under the direction of a physician. Additional California licensed health professionals (RNs or LVNs) must be available to monitor vital signs and respond to emergencies at the clinic at all times.

3.12-H0022 Intervention Services (Early Intervention)[18]

HCPCS Definition
Alcohol and/or drug services; intervention services (Early Intervention), any planned intervention that may assist a person to abstain from AOD use.

Standards of Care
Early intervention services are activities that are considered sub-clinical (classified by ASAM as 0.05), and designed to treat individuals whose risk factors are related to substance abuse but do not meet diagnostic criteria for substance use related disorders.

Staffing Standards
The qualifications of providers performing early intervention activities will vary depending on the individual or population that is served; however, all staff members must be trained in the treatment and prevention of disease progression.

3.13-H0048 Alcohol and/or Drug Testing (collection and handling only)[19]

HCPCS Definition
Alcohol and/or other drug testing: Collection and handling only, specimens other than blood-including hair, saliva, urine, or other specimens for the purposes of analysis for the presence of alcohol and/or other drugs, and does not include the laboratory analysis of such specimens.

Standards of Care
Personnel responsible for collecting and handling of specimens must follow established procedures that protect against contamination, ensure the chain of custody, and document collection within the client's record.

Staffing Standards
While requiring training in methods of collection and handling, certification is not required for personnel performing these services.

[18] Mee-Lee, M.D., David. "Overview of the ASAM Patient Placement Criteria, Second Edition Revised (ASAM PPC-2R)." *SAMHSA Co-Occurring Center for Excellence.* June 2005. Accessed 16 May 2011. <http://coce.samhsa.gov/cod_resources/PDF/ASAMPatientPlacementCriteriaOverview5-05.pdf >

[19] HHS Mandatory Guidelines for Drug Testing: 75 FR 22809. Updated April 2010.

3.14-H0049 Alcohol and/or Drug Screening[20,21]

HCPCS Definition

Alcohol and/or Drug Screening-Process designed to identify an individual who has an alcohol and/or drug use problem or is at risk for developing one by evaluating responses to questions about alcohol and/or other drug use. A valid brief questionnaire about the context, frequency, and amount of alcohol and/or other drug use can be used to examine substance use patterns. Examples of valid questionnaires are the AUDIT (Alcohol Use Disorder Identification Test), MAST (Michigan Alcohol Screening Test), DAST (Drug Abuse Screening Test), and ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test). A positive screen results in a recommendation for a brief intervention (H0050-Brief Intervention) for individuals with an alcohol and/or drug use problem or at risk of developing one, or a referral to a substance abuse treatment program for individuals with severe alcohol and/or other drug abuse and dependence.

Standards of Care

The screening process must evaluate an individual for the possible presence of a substance use disorder and determine whether an assessment is required. Screening generally results in a "yes" or "no" answer. Validated tools for alcohol or drug use screening includes: AUDIT, MAST, MAST-Geriatric (MAST-G), CAGE (Cut Down, Annoyed, Guilty, Eye-opener) Survey, Substance Abuse Subtle Screening Inventory (SASSI), and DAST. Additionally, TWEAK (Tolerance, Worried, Eye-opener, Amnesia, and K/Cutting down on alcohol consumption), T-ACE (Take, Annoyed, Cut Down, Eye-opener), and 5Ps Plus (Parents, peers, partner, past, and present) are three standard screening tools that have been specifically designed for pregnant women.

Staffing Standards

Most screening tools require little to no specialized training to administer. Substance abuse certification is not required.

3.15-H0050 Brief Intervention[22]

HCPCS Definition

Alcohol and/or drug services, brief intervention, per 15-minute segment—a brief one-on-one session in which concerns about an individual's alcohol and/or other drug use are expressed.

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20 Michigan Quality Improvement Consortium. "Screening, diagnosis and referral for substance use disorders." *Southfield (MI): Michigan Quality Improvement Consortium*. 1 August 2009.

21 Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97-3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997.

22 Center for Substance Abuse Treatment. *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99-3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Standards of Care
Brief Intervention is usually provided after an alcohol and/or drug screen (H0049-Alcohol and/or Drug Screening). There are six elements that are considered critical for effective brief interventions:

- Feedback is given to the individual about personal risk or impairment.
- Responsibility for change is placed on the participant.
- Advice to change is given by the clinician.
- Menu of alternative self−help or treatment options is offered to the participant.
- Empathic style is used by the counselor.
- Self−efficacy or optimistic empowerment is engendered in the participant.

A brief intervention consists of five steps that incorporate the elements listed above. Providers are not obligated to use all five steps in each session, but there must be a well-defined reason for eliminating any step.

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Staffing Standards
Brief interventions must be performed, at a minimum, by registered (within the last five years), certified, and/or licensed counselors.

3.16-J2315 Naltrexone (Vivitrol)

HCPCS Definition
Injection of Naltrexone (Vivitrol), depot form, 380 mg/vial.

Standards of Care
Naltrexone injection (Vivitrol) shall be administered by injection into the muscle of the buttocks by a healthcare provider once every four weeks.

Naltrexone injection is used along with counseling and social support to help people who have stopped drinking large amounts of alcohol or abusing opiate medications from resuming use. Naltrexone injection must not be used to treat people who are still drinking alcohol, people who are still using opiates or street drugs, or people who have used opiates within the past ten days.

Staffing Standards
Injections must be administered by a licensed physician, physician's assistant, RN, or LVN.

3.17-S0281 Medical Home Care Coordination Maintenance

HCPCS Definition
Medical Home Program, comprehensive care coordination and planning, maintenance of plan-maintenance of cross-service care coordination. This definition and procedure code is simply a placeholder in anticipation of heath care reform.

Standards of Care
To be determined upon implementation of health care reform.

Staffing Standards
To be determined upon implementation of health care reform.

3.18-S5190 Wellness Assessment

HCPCS Definition
Wellness assessment performed by a non-physician**.** The assessment of an individual by a clinician to measure quality of life indicators using published psychometric scales.

Standards of Care
Clinicians should use a standardized and relevant instrument for data collection, which measures progress along a continuum of identified quality-of-life indicators. Examples of relevant instruments include The Life Situation Survey (LSS; Chabon, 1987). This survey is an example of a published survey tool that is a series of 20 brief questions that span several areas of life quality. Other examples of reliable and valid scales are: The World Health Organization Quality of Life (QOL) Survey (WHOQOL-BREF; WHOQOL Group, 1998) 26-items, Medical Outcome Study Health-Related Short Form (MOS-SF-36; Ware & Sherbbourne, 1992). These tools collect information across multiple domains including: Physical Health, Psychological, Social Relationships, Environment and General QOL.

Staffing Standards
Wellness assessments must be performed by a RN, Licensed Clinical Social Worker, Marriage Family Therapist, Licensed Psychologist, or an individual with a Master's degree in Social Work.

3.19-S9075 Smoking Cessation Treatment[23]

HCPCS Definition
Smoking cessation treatment per 15-minute segment.

[23] Zhu et al. "Telephone Counseling for Smoking Cessation: What's in a Call?" *JCD 75*: 93-102. 1996.

Standards of Care

Smoking cessation programs may be conducted on either an individual or group basis and the duration of the program may range from several days to several months.

Counseling topics for the first session include:

- Treatment overview and rationale
- Motivation and self efficacy
- Physical and mental health considerations
- Smoking and quitting history
- Quitting methods
- Environmental considerations
- Planning
- Setting a quit date

Topics for follow up sessions include:

- Quit status
- Withdrawal review
- Pharmacotherapy review
- Challenges and smoking events
- Motivation and self-efficacy
- Support
- Future plan
- Self-image

Staffing Standards
Individuals facilitating tobacco cessation programs must complete training in tobacco cessation and dependence.

3.20-S9976 Lodging[24]

HCPCS Definition
Lodging, per diem, not otherwise specified.

[24] 9 CCR § 11000. California Administrative Code: *Title 9. Rehabilitative and Developmental Services, Division 4. Department of Alcohol and Drug Programs, Chapter 7. Resident Run Housing Program (RRHP).*

Standards of Care

The California Code of Regulations (CCR) details requirements for the ownership and administration of a resident-run housing program (RRHP) in accordance with the Health and Safety Code and Public Health and Service Act. Requirements within this state regulation specific to the home and residents are included below as the standard for alcohol and drug-free living centers or sober living homes in the state of California.

9 CCR § 11000

- Each RRHP group home shall consist of no more than six residents, who are recovering from alcoholism and/or drug addiction.
- Minor children of group residents may live with their parents in the group home if:
    1. The parent makes arrangements to care for the child(ren) if the parent is expelled from the group home pursuant to Subsection (f)(2) of this regulation;
    2. The parent signs a written statement specifying the arrangements that have been made to care for the child(ren) if the parent is expelled from the group home;
    3. If the arrangements the parent has made involve the other residents of the group home, the residents shall sign a written statement agreeing to comply with the arrangements the parent has made to care for the child(ren).
- All residents of the home shall be recovering from alcoholism or drug addiction.
- The group home shall be alcohol and drug free. As used in this chapter, "alcohol and drug free" means that:
    1. No alcohol or illicit drugs shall be allowed in the group home or on the premises.
    2. The group residents shall expel from the group home any resident who resumes using alcohol or illicit drugs.
    3. As used in this chapter, "illicit drugs" means any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except:
        a. Drugs or medications prescribed by a licensed physician or other person authorized to prescribe drugs, pursuant to Section 4036, Chapter 9, Division 2 of the Business and Professions Code, and used in the dosage and frequency described, excluding the use of medical marijuana; or,
        b. Over-the-counter drugs or medications, used in the dosage and frequency described on the box, bottle, or package insert.
- The group home shall be habitable. As used in the chapter, "habitable" means that the group home shall have a minimum of:
    1. One working gas or electric stove,
    2. One working electric refrigerator,
    3. Hot and cold running water,

4. One water flush toilet, in working condition,
5. One bathtub, shower, or bath/shower combination, with hot and cold running water, and in working condition.
6. Electric lighting,
7. A working furnace or other form of heating,
8. An individual bed for each resident and enough bedrooms to accommodate all residents of the house, so that no more than four residents are required to share a bedroom. Each bunk of a bunk bed shall be considered an individual bed for purposes of this regulation.

- The group home shall be resident run [defined in accordance with Section 11002(a) (17)].

Staffing Standards
Not applicable.

3.21-T1007 Treatment Plan Development/Modification[25,26]

HCPCS Definition
Alcohol and/or substance abuse services, treatment plan development and/or modification: means design or modification of the treatment or service plan for substance use disorders. This may be the initial plan for a client beginning treatment or the modification of a plan for a client already in treatment. It is typically a scheduled service not necessarily delivered in conjunction with other treatment. This service may require the participation of clinicians and specialists in addition to those usually providing treatment.

Standards of Care
Treatment plans must include the following steps:

- Initiate collaboration with referral source.
- Obtain, review, and synthesize all relevant screening, assessment, and initial treatment-planning information.
- Identify the client's readiness for treatment and stage of change.
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to the following.
    - Develop the individualized problem list.
    - Develop the short- and long-term goals related to identified problems.

[25] Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

[26] 9 CCR § 10305. California Administrative Code: *Title 9. Rehabilitative and Developmental Services, Division 4. Department of Alcohol and Drug Programs, Chapter 4. Narcotic Treatment Programs, Subchapter 5. Patient Treatment.*

- Designate appropriate treatment interventions and objectives.
- Delineate frequency of treatment activities.
- Identify factors affecting duration of care and requirements for discharge.
- Delineate client participation in treatment planning process

- Coordinate all treatment activities with services provided to the client by other resources.

For narcotic treatment programs, additional guidance on the completion of treatment plans is provided in Section 10305, Title 9, of the CCR.

Staffing Standards

Staffing standards are in line with H0006-Case Management above. Case managers must possess an equally extensive body of knowledge and master a complex array of skills as other specialists in order to provide optimal services to their clients. Case managers must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), but must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy.

All professionals who provide services to substance abusers, including those specializing in case management, must possess particular knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain "transdisciplinary foundations" created by the ATTCs. These foundations—understanding addiction, treatment knowledge, application to practice, and professional readiness—are articulated in 23 competencies and 82 specific points of knowledge and attitude.

Examples of competencies include:

- Understanding a variety of models and theories of addiction and other problems related to substance use.
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process.
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits.
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities into clinical practice.
- Understanding the value of an interdisciplinary approach to addiction treatment.

3.22-T1012 Skills Development[27]

HCPCS Definition
Alcohol and/or substance abuse services, skills development—Activities to develop client community integration and independent living skills. Services may be provided in individual or group settings but not necessarily at scheduled events, and may be offered in the context of other normal activities, such as education or employment.

Standards of Care
Skills development is an integral part of the rehabilitation process for individuals with substance use disorders, reducing aggression and withdrawal, and teaching the skills necessary to successfully re-integrate into the community. While the breadth of skills that are addressed may vary, skills development training is generally comprised of five high-level components:

- Instructions
- Modeling
- Rehearsal
- Feedback
- Homework

Staffing Standards
Skills development training must be provided by substance abuse counselors registered, certified, and/or licensed by an accredited, ADP-approved, certifying organization.

3.23-99203 Physical Evaluation/Exam-30 Minutes, 99204 Physical Evaluation/Exam-45 Minutes, 99205 Physical Evaluation/Exam-60 Minutes

HCPCS Definition
Physical evaluation/exam (30, 45, or 60 minutes) of a patient by a physician, face to face.

Standards of Care
Physical exams are administered on admission to a narcotic treatment program. The physical exam must assess the individual's current medical condition and overall health, presence of any co-occurring disorders, and presence of physical indicators of narcotic addiction.

Staffing Standards
For codes 99203, 99204, and 99205, the exam must be administered by a California licensed physician.

[27] Pentz, MA. (1983) *Prevention of Adolescent Substance Abuse through Social Skills Development.* pp. 195-232.

3.24-X9999 Residential Room and Board

Definition
Residential Room and Board: Room and board, per diem, residential.

Standards of Care
Residential Treatment Programs room and board will be provided in a facility that is licensed by the state of California.

Staffing Standards
Not applicable.

4: CONFIDENTIALITY[28]

Each provider shall develop and maintain Confidentiality/Privacy practices and standards that meet the County of Los Angeles Department of Public Health requirements. These standards must address issues related to confidentiality of personal and medical information obtained during the course of professional services and meet the requirements included in, but not limited to:

- Title 42 Code of Federal Regulations, Part 2
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Title 45 Code of Federal Regulations, Part 164 (Privacy Rule)
- State of California, Department of Alcohol and Drug Programs, Privacy Practices

Providers shall provide a copy of the Confidentiality/Privacy practices to clients upon intake and make those practices accessible to clients upon request.

5: CLIENT RIGHTS AND RESPONSIBILITIES[29]

Each provider shall develop and maintain Client Rights and Responsibility practices and standards that meet the County of Los Angeles Department of Public Health requirements.

These practices and standards shall specify that each client shall have rights that include, but are not limited to:

[28] State of California, Health and Human Services Agency, Department of Alcohol and Drug Programs. *Treatment Standards for Substance Use Disorders: A Guide for Services.* Spring 2010.

[29] State of California, Health and Human Services Agency, Department of Alcohol and Drug Programs. *Treatment Standards for Substance Use Disorders: A Guide for Services.* Spring 2010.

- Confidentiality, as provided for in Title 42, Code of Federal Regulations (CFR), Part 2; and HIPAA Privacy Rule (45 CFR, Part 164), and summarized in the Notice of Privacy Practices, California Department of Alcohol and Drug Programs, October 2007;
- Be accorded dignity in contact with staff, volunteers, board members, and other persons;
- Safe, healthful, and comfortable accommodations to meet his/her needs;
- Be free from verbal, emotional, physical abuse, and/or inappropriate behavior;
- Be informed by the program of the procedures to file a grievance or appeal discharge;
- Freedom from discrimination; and
- Reasonable access to her/his file.

These practices and standards shall also specify that each client has responsibilities that include:

- Honoring the privacy of others;
- Treating others with respect and dignity;
- Asking questions until I understand what is expected of me;
- Letting the provider know if my referral connection is not a good one;
- Letting staff know about my family or other support system so they can be involved in my care if I choose; and,
- Participating in opportunities to strengthen my recovery.

Each provider shall post a copy of the Client Rights and Responsibilities in a location visible to all participants.

6: NONDISCRIMINATION[30]

Each provider shall maintain nondiscrimination practices that assure that they will not discriminate in the provision of services on the basis of ethnic group identification, religion, age, sex, color, sexual orientation, gender identification or disability, pursuant to Title VI of the Civil Rights Act of 1964 (Section 2000d, Title 42 U.S.C.); the Rehabilitation Act of 1973 (Section 794, Title 29, U.S.C.); the Americans with Disabilities Act of 1990 (Section 12132, Title 42 U.S.C.); Section 11135 of the California Government Code; and Chapter 6 (commencing with Section 10800), Division 4, Title 9 of the California Code of Regulations.

[30] State of California, Health and Human Services Agency, Department of Alcohol and Drug Programs. *Treatment Standards for Substance Use Disorders: A Guide for Services.* Spring 2010.

SECTION VII–COST IDENTIFICATION AND ANALYSIS

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1: INTRODUCTION

One of the primary goals of the Rate Study is to recommend a new fee schedule for SAPC contracted services. To develop that fee schedule, the MGT team first performed detailed cost identification and analysis of existing and relevant data sources. After those tasks were completed, the MGT team developed a rate-setting methodology and calculated the actual fee schedule for SAPC services.

In conjunction with the work steps identified to complete the service definitions and standards of care identified in Sections V. and VI., the MGT team performed a number of steps to conduct the cost identification and analysis. Those actions included:

- Conducting focus group meetings.
- Meeting with SAPC staff to discuss current and historic contracting practices.
- Creating a Web-based cost reporting system.
- Requesting that providers conduct revisions and make additions to cost reports, including adding job categories, FTEs, and service units.
- Analyzing cost report data.

As part of the focus group meetings as detailed in Section III of the Rate Study, the MGT team gathered information from the providers on the current cost reports and cost reporting process. The information obtained in these focus groups helped identify reporting capacities and potential limitations within the provider community. In addition to the focus groups, the MGT team met with SAPC staff to get a better understanding of the current contracting and cost reporting processes. From both of these steps, the MGT team gathered the information necessary to understand the current cost reports and steps the providers and SAPC take in the cost reporting process. These steps also helped illuminate strengths and shortcomings of the current process and report, and identified areas that the MGT team needed to address in the Rate Study.

2: COST IDENTIFICATION

The MGT team relied heavily on SAPC provider data that had previously been filed with SAPC for the fiscal year 2009-10 cost reporting period. The cost reports were compiled by SAPC staff and were available electronically through the MGT team's Web-based cost reporting system that the MGT team built for the purposes of this rate study. To calculate the most accurate rates possible, it was imperative that all costs were reported accurately and completely. To validate the cost information, the MGT team requested that providers log into the Web-based cost reporting system to review, update, and validate the information for rate-setting purposes. Each provider was asked to:

- Review cost report data for each contract exhibit.
- Edit cost report data to reflect the actual costs of providing SAPC services.

- Edit job titles to match choices from the MGT list:
  - Case Manager
  - Physician–CA Licensed
  - RN–CA Licensed
  - LVN–CA Licensed
  - Psychologist–CA Licensed
  - Substance Abuse Counselor–Registered
  - Substance Abuse Counselor–Certified
  - Substance Abuse Counselor–Licensed
  - Substance Abuse Counselor–Non-Registered, Non-Certified, Non-Licensed
  - Mental Health Therapist–CA Licensed
  - Marriage and Family Therapist (MFT)
  - Social Worker (LCSW)
  - Social Worker (SW)
  - Program Assistant
  - Administrative Assistant
  - Financial Officer
  - Executive Director
- Provide more detailed information on:
  - FTEs
  - Units and Revenue

The MGT team requested that providers review all schedules for accuracy and completeness and encouraged providers to make edits to the information where it was needed, and to add additional cost items, when applicable. In this way, the MGT team anticipated that providers would be able to report the true costs to the facility, and not necessarily the costs that are reported to fit under the County-approved budgets. Training for the Web-based cost reporting system took place on February 7 and 8, 2011 and providers were given two weeks (until February 22, 2011) to log into the system and make updates to their cost reports.

MGT received cost report data from SAPC for 108 adult outpatient and residential substance abuse providers. At the end of the Web-based cost reporting time period, 24 providers had participated in the process (22% of all providers). While the MGT team and SAPC preferred to have 100 percent participation in the cost reporting process, there was a satisfactory level of participation to perform data analysis on the cost report data.

In addition to the initial and revised cost report data, the MGT team also utilized other data sources from SAPC, including:

- Excel Workbook: "ALL RATES_FY2009-10 (02_3_11)" (Provided by SAPC on February 3, 2011)
  - Modality
  - SPA
  - Units of Service (UOS)
  - UOS Individual
  - UOS Group
  - Target Population
- Excel Workbook: "3-Years combine" (Provided by SAPC on October 27, 2010)
  - Mode of Service
  - Program
- Focus Group Findings
- Additional Communication with Providers
  - Phone, email, trainings

Finally, the MGT team conducted research of other payer sources for the types of services for which SAPC contracts. We also conducted research of best practices.

3: DATA ANALYSIS

To assess how much the providers' cost experience should play a role in the fee schedule development, the MGT team analyzed data reported by the SAPC providers through the Web-based cost reporting system. The MGT team used a combination of revised cost report data (for those providers that participated in the update process) and as filed cost report data (for those providers that did not participate in the update process) to conduct the data analysis.

Chart A–Cost Distribution

The MGT team began its data analysis by looking at overall costs for the adult outpatient and residential substance abuse contracts used in our rate study. The cost data is deemed "revised," as it was taken from the Web-based cost reporting system. There are seven key categories of costs that the MGT team attempted to analyze for each contract:

- Salaries
- Benefits
- Facility Rent/Lease or Depreciation
- Equipment and Other Assets
- Other Direct Costs
- Fixed Asset Depreciation
- Administrative Costs

In Table 1 on the following page, the costs for these seven key cost components are summarized and broken out by SPA. There is no specific consideration given to service modalities in this analysis (that is, all service modalities are represented below), as a total. As to be expected, salary is the largest cost component, with other direct costs the second largest cost category. In fact, salaries represent about 42% of total expenses for providers across the county.

Table 1. Expense Categories Totaled by Service Planning Area (SPA)

Description	1	2	3	4	5	6	7	8	Total
Salary	$1,251,223	$2,918,173	$4,607,324	$4,519,325	$679,734	$4,791,074	$3,308,845	$5,114,540	**$27,190,238**
Benefit	$241,680	$637,234	$1,235,799	$1,134,465	$238,875	$1,154,330	$922,892	$1,664,251	**$7,229,527**
Facility Rent/Lease or Depreciation	$264,106	$659,451	$634,691	$753,594	$101,149	$761,897	$516,932	$933,074	**$4,624,895**
Equipment and Other Assets	$6,305	$17,904	$111,277	$40,142	$12,274	$120,537	$62,179	$135,962	**$506,579**
Other Direct Costs	$476,857	$1,295,551	$2,279,409	$2,109,046	$493,248	$2,067,917	$1,553,082	$2,630,347	**$12,905,458**
Equipment Depreciation	$414,328	$535,455	$508,705	$359,496	$55,277	$615,070	$240,315	$360,865	**$3,089,511**
Administrative Overhead	$23,327	$374,548	$1,065,468	$866,978	$276,155	$1,002,406	$772,992	$1,074,272	**$5,456,146**
Administrative Overhead	$0	$79,747	$258,221	$51,149	$0	$870,625	$56,885	$209,644	**$1,526,271**
Administrative Overhead	$938,649	$605,291	$474,338	$116,854	$0	$123,394	$236,145	$78,717	**$2,573,388**
Total	**$3,616,476**	**$7,123,355**	**$11,175,232**	**$9,951,050**	**$1,856,712**	**$11,507,250**	**$7,670,267**	**$12,201,671**	**$65,102,012**

Notes: Where $0 is reported for a particular cost category and SPA, there has been no cost data provided for that category by contracts within that SPA.

Some of the individual totals in this table differ by $1 due to rounding.

The MGT team also ran the same cost category analyses for Residential Services and Outpatient Counseling (Individual and Group) to determine if there were significant differences between the cost structures of these services. Table 2, Residential Services, below, identifies that approximately

50% of cost is attributed to salaries and benefits, 24% to Other Direct Costs, and over 14% to Administrative Overhead. Residential Services has a greater Other Direct Services cost percentage compared to the average of all service modalities. Tables analyzing the percent of total costs for each cost category can be found in Appendix B.

Table 2: Residential Services Expense Categories, by SPA

Description	1	2	3	4	5	6	7	8	Total
Salary	$488,281	$1,673,076	$2,381,748	$2,832,523	$344,820	$2,127,792	$1,952,983	$1,824,057	**$13,625,282**
Benefit	$95,339	$382,488	$652,568	$677,770	$115,001	$570,209	$452,317	$583,882	**$3,529,574**
Facility Rent/Lease or Depreciation	$39,662	$271,309	$167,381	$427,104	$45,344	$296,839	$171,672	$550,760	**$1,970,071**
Equipment and Other Assets	$3,150	$7,387	$67,329	$23,514	$7,714	$56,541	$30,407	$72,797	**$268,839**
Other Direct Costs	$186,539	$851,630	$1,680,571	$1,712,664	$373,191	$928,250	$985,794	$1,433,642	**$8,152,281**
Equipment Depreciation	$5,921	$78,491	$129,961	$171,523	$17,975	$88,080	$21,853	$65,468	**$579,272**
Administrative Overhead	$0	$271,023	$576,335	$459,813	$156,545	$367,141	$323,823	$366,500	**$2,521,181**
Administrative Overhead	$0	$50,782	$138,143	$29,962	$0	$836,829	$54,129	$50,084	**$1,159,930**
Administrative Overhead	$286,499	$66,725	$233,885	$116,854	$0	$87,060	$236,145	$64,573	**$1,091,741**
Total	**$1,105,391**	**$3,652,911**	**$6,027,922**	**$6,451,727**	**$1,060,590**	**$5,358,742**	**$4,229,124**	**$5,011,763**	**$32,898,171**

Note: Some of the individual totals in this table differ by $1 due to rounding.

The MGT team also reviewed the costs for the Counseling modalities in Table 3. In comparison with the previous analyses of residential services and aggregated costs, more costs were attributed to salary and fringe for this service (over 59%), likely because of the consumer facing focus and lower administrative and other overhead costs.

Table 3: Counseling Services Expense Categories, by SPA

Description	1	2	3	4	5	6	7	8	Total
Salary	$411,748	$282,742	$465,537	$815,256	$113,561	$658,335	$689,991	$501,224	**$3,938,393**
Benefit	$78,048	$51,007	$96,128	$211,861	$29,903	$151,452	$165,658	$165,077	**$949,134**
Facility Rent/Lease or Depreciation	$137,599	$82,460	$102,346	$120,556	$18,993	$104,215	$86,226	$101,213	**$753,608**
Equipment and Other Assets	$405	$792	$10,261	$10,042	$11	$11,962	$17,798	$8,064	**$59,334**
Other Direct Costs	$189,730	$76,001	$133,820	$148,793	$41,254	$235,354	$238,608	$195,696	**$1,259,256**
Equipment Depreciation	$0	$11,950	$19,230	$14,206	$5,486	$109,264	$15,709	$15,626	**$191,471**
Administrative Overhead	$8,976	$12,887	$20,575	$236,039	$31,079	$65,171	$116,495	$70,427	**$561,648**
Administrative Overhead	$0	$21,782	$53,554	$2,550	$0	$33,795	$2,755	$43,866	**$158,303**
Administrative Overhead	$323,836	$20,489	$8,104	$0	$0	$36,334	$0	$0	**$388,763**
Total	**$1,150,342**	**$560,110**	**$909,554**	**$1,559,303**	**$240,287**	**$1,405,882**	**$1,333,240**	**$1,101,192**	**$8,259,911**

Note: Some of the individual totals in this table differ by $1 due to rounding.

It is important for SAPC to continue tracking expenditures by category for each contract. The cost distributions tables above could be utilized by SAPC in future rate-setting efforts to limit payments for services up to established maximum levels as defined by annual pay. For example, some health and human service programs limit the administrative rate to 20% when establishing rates of cost reports. A similar approach could be established for the SAPC network. Additionally, SAPC can use the data from the cost distribution tables to create "lodging" or "hoteling" rates and track increases or decreases in actual costs.

Chart B–Staffing and Productivity Analysis

Per our scope of work, the MGT team was required to conduct an analysis on staffing and productivity. Because a limited number of providers submitted FTE and salary data, we could not use the information for rate-setting purposes. The MGT team instead relied on the Bureau of Labor Statistics (BLS) for the Los Angeles County area. The complete analysis of the provider reported salary and FTE data can be found in **Appendix C: Salary and Productivity Analysis**.

SECTION VIII—RATE METHODOLOGY, SCHEDULES, AND IMPACT

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The Social Security Act (SSA) outlines for states the general principles to which reimbursement must adhere. For example, Section 1902(a)(30)(A) of the SSA requires the state to:

> ."... provide methods and procedures relating to utilization of, and the payment for, care and services available under the plan ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

This language and the goals stated are appropriate for the SAPC providers, and SAPC must emphasize that payments adhere to four principles: efficiency, economy, quality of care, and access. The MGT team's discussion of a rate development methodology for SAPC will focus on these four principles and how each rate setting methodology can or cannot promote these four principles.

1: RATE-SETTING TERMINOLOGY

A review of California literature and discussions with various stakeholders indicate that reimbursement terms can be used in different ways. To assist the readers of this report, the following definitions have been established for frequently used terms.

- ***Budgeted cost**:* Anticipated or projected amounts that might be incurred for a fiscal period. Not actual costs, even though they are frequently referred to as costs.
- ***Bidding**:* Practice of establishing payment rates by collecting bids from potential providers.
- ***Cost-based**:* Provider-specific rate determined by using the provider's own cost experience or budget projections.
- ***Cost center**:* An activity, organization, or object for which cost information is collected. Examples include direct service costs, indirect costs, and general and administrative costs.
- ***Efficiency incentives**:* Payment of some portion of the difference between an upper limit and actual costs below the limit.
- ***Flat rates**:* Rates established by dividing budgeted, available, or historical dollars by case load projections, anticipated units of service, or actual units of services provided. May also be set through negotiation between payers and providers or be dependent upon the persuasive ability of providers to argue for a particular rate.
- ***Fixed costs**:* Expenses that do not change in proportion to the activity of a business.
- ***Historical cost**:* Actual cost experience determined from a prior completed fiscal period.
- ***Marginal costs**:* Change in total cost attributable to the production of an additional unit of service.
- ***Peer groups**:* Providers with similar characteristics such as size, specialty, ownership, or location; for example, rural or urban.

- ***Price-based****:* Standard price established for all providers within the state or peer group. Can be developed based on benchmarks such as means, medians, or percentiles of the actual cost experience of the provider group. Can also be based on an analysis of a hypothetical provider and the average market prices it would pay for goods and services to produce its products.
- ***Projected inflation factors****:* Factor used to set the amount of money that providers will receive to compensate for changes in their costs during the rate period.
- ***Prospective reimbursement****:* Payment of rates based on historical data or budget projections with no subsequent settlement to actual costs.
- ***Rebasing****:* Practice of periodically collecting cost information from providers and using the information to change the rates paid.
- ***Retrospective reimbursement****:* Payment of a previously established rate that is settled to actual costs at the end of a set period.
- ***Upper limits (also referred to as ceilings)****:* Maximum amounts per cost center that will be reimbursed; usually arrived at by arraying each provider's costs in a frequency distribution and picking a point in the distribution such as 115% of the distribution's median value.
- ***Variable costs****:* Expenses that change in relation to the activity of the business.

2: RATE-SETTING PRACTICES

Rate-setting systems may be described on three dimensions:

The degree to which a provider's experience is considered in the methodology.
A reimbursement methodology may be provider-independent or provider-dependent. Rates that are not based on a particular provider's costs experience, their charges for services, or their projected costs are provider-independent rates. For example, both flat-rate and price-based systems tend to be provider-independent. In these systems, providers are reimbursed according to a set flat rate or an established price regardless of their individual cost experience. If these flat rates are not incrementally adjusted for inflation or rebased, their continued use has the effect of reducing the value of the reimbursement to providers. A provider-dependent rate system is one in which the reimbursement to each provider is linked in some way to its particular historical costs, projected amounts, or bids.

The degree to which rates are adjusted later based on provider cost experience during the rate payment period.
There is considerable variability in the design of rates and rates can either be retrospective or prospective in nature. Retrospective systems establish an interim rate for a future period by using either budget projections or historical costs of a prior period. After the rate period ends and actual cost experience is determined, there is an adjustment made from interim rates to actual cost experience. In calculating the settlement to actual costs, states frequently set upper limits or ceilings by cost center, paying an amount equal to the lower of the actual cost experience or the calculated upper limit or ceiling. These limits may be established for peer groups or for all providers as a single group. If limits or ceilings are set too low, this retrospective system resembles a price-based system.

Retrospective systems are often more difficult to administer because of the administration of the settlement. In the last ten years, both state Medicaid and federal Medicare payments have moved away from retrospective reimbursement systems.

Prospective systems typically use some combination of budgeted and historical costs trended forward to establish reimbursement rates. Whatever the basis for establishing rates, they are not settled to actual costs at the end of the rate period. Prospective systems can also incorporate upper limits or ceilings. For providers with costs below the upper limits, there may be efficiency incentives. In addition to upper limits, these systems may incorporate lower limits or floors. If there is a floor, the provider is paid its cost or the floor, whichever is greater. The rates for these systems are based on cost reports submitted by the providers. The rate calculation uses allowable costs, as defined by the state, frequently divided into cost centers.

The degree to which a rate-setting methodology is rebased.
Reimbursement methodologies can vary in the length of time a rate is used. There are no federal requirements that a Medicaid rate be rebased or have an inflation factor added to it. Once set, rates are normally in place for a specified period of time. Following this pre-determined payment period, rates should be evaluated and potentially adjusted for inflation. Without rate increases to account for the impact of inflation, providers would need to reduce costs by the amount of inflation in order to maintain an even status. It is important to periodically evaluate the reasonableness of rates and rebase rates, as indicated.

3: OUTPATIENT RATE SETTING

The MGT team developed a rate for each non-residential HCPCS/CPT code. Each rate is based on the following cost components:

- Primary staff salary per expected FTE commitment required to complete each service;
- Supervisory staff salary per expected FTE commitment required to complete each service; and
- Average administrative, overhead, facility, and other direct costs as reported on the cost report.

For those codes where the standard HCPCS definition does not define a unit of measure, the MGT team employed both Medicaid common practices and evidence-based research to determine the appropriate unit of service. The calculated rates were then compared to Medicare, Medi-Cal, and other state Medicaid rates, where applicable, to test for reasonableness.

Staffing Requirements

The established HCPCS service codes were first divided into medical and behavioral codes. For behavioral codes, potential staff levels include Registered/Certified Counselors, Licensed Counselors, and Marriage and Family Therapists. For medical codes, staff levels include LVNs, RNs, and Physicians.

While there are other qualified providers that may provide direct behavioral services, such as Licensed Social Workers, the staff titles were chosen to reflect the spectrum of qualified provider salaries.

Per the established Standards of Care, the minimum qualification for all behavioral codes is a Registered Counselor. Thus, the base rate for each service assumes that a Registered Counselor is the primary provider. However, since a Registered Counselor only remains at that level for one year before they must complete the certification process, the salary used to determine the minimum rate is based on the salary of a Certified Counselor. For those services that require a singular focus, or one-on-one interaction with the client, one FTE is assigned to the primary provider. For services that are provided on a group basis, 0.25 FTE was assigned to the primary provider. The HCPCS definition of a group session defines the number of participants as greater than two. As the range of group sizes is too broad to justify the use of an average in determining a rate decrease for group services, the MGT team determined that 0.25 FTE per unit provides a rate that is the most comparable to Medicaid rates while aligning with the HCPCS definition of a group session.

In addition to the primary provider, a fractional FTE was also assigned to each service to represent supervisory requirements. The MGT team assumes a 0.25 FTE supervisory requirement for individual counseling, intervention, and assessment, and a 0.1 FTE requirement for individual skills development, case management, screening, and treatment planning services. For services that occur on a group basis, a 0.0625 supervisory FTE was assigned, reducing the supervisory component by the same rate as the primary component.

For the Smoking Cessation Treatment and Skills Development service codes, which traditionally are used for both individual and group sessions, a group modifier was added to reduce the FTE count to the above described group ratios.

The average fringe rate of 24%, as calculated from the cost report data, was added to the salary for each staff level. A “productive hour” estimate of 1,950 hours per year was then applied to the total compensation for each staff level in order to calculate an hourly rate.

Administrative Overhead and Non-Salary Direct Costs

From the cost report data, the MGT team calculated an average administrative overhead rate and average non-salary direct cost rate. Of the total costs associated with non-residential services, administrative overhead accounted for about 30% of total costs and non-salary direct costs accounted for about 27% of total costs. The staff specific rate described above was augmented by 57.4% to account for these additional costs.

The chart on the following pages displays the total calculated rate for each HCPCS code.

Service	Staff	Salary	Fringe	Hourly Rate with Productivity Factor Applied	FTE Assigned	Hourly Rate per FTE	Time per Unit of Service (Hours)	Rate per Employee	Total Salary and Fringe per Unit of Service	Total Rate per Unit of Service (Includes 57.4% Administrative and Non-Salary Direct Cost)
H0001 Assessment	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	1.0000	$24.14	$32.37	$75.99
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.25	$8.23	1.0000	$8.23		
H0003 Laboratory Analysis	Laboratory Technician	$49,275	$11,826	$31.33	1.00	$31.33	0.1667	$5.22	$5.22	$12.26
H0004 Individual Counseling	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$8.09	$19.00
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.25	$8.23	0.2500	$2.06		
H0005 Group Counseling	Registered/Certified Counselor	$37,960	$9,110	$24.14	0.25	$6.03	0.2500	$1.51	$2.02	$4.75
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.06	$2.06	0.2500	$0.51		
H0006 Case Management	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$6.78	$15.92
	Licensed Counselor	$46,953	$11,269	$29.86	0.10	$2.99	0.2500	$0.75		
H0015 Intensive Outpatient Treatment	Registered/Certified Counselor	$37,960	$9,110	$24.14	0.42	$10.06	3.0000	$30.17	$35.53	$83.39
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.05	$1.78	3.0000	$5.35		

Note: ***For presentation purposes, dollar amounts in this table are shown as rounded to the nearest cent, although the actual amounts are carried to multiple decimal places and are used in the specific calculations.***

Service	Staff	Salary	Fringe	Hourly Rate with Productivity Factor Applied	FTE Assigned	Hourly Rate per FTE	Time per Unit of Service (Hours)	Rate per Employee	Total Salary and Fringe per Unit of Service	Total Rate per Unit of Service (Includes 57.4% Administrative and Non-Salary Direct Cost)
H0016 Medical Intervention in an Ambulatory Setting	Licensed Vocational Nurse	$49,124	$11,790	$31.24	1.00	$31.24	0.2500	$7.81	$16.70	$39.20
	Registered Nurse	$77,594	$18,623	$49.34	0.50	$24.67	0.2500	$6.17		
	Physician	$171,149	$41,076	$108.83	0.10	$10.88	0.2500	$2.72		
H0020 HG, Methadone Administration	Licensed Vocational Nurse	$49,124	$11,790	$31.24	1.00	$31.24	0.1667	$5.21	$6.21	$14.58
	Registered Nurse	$77,594	$18,623	$49.34	0.10	$4.93	0.1667	$0.82		
	Physician	$171,149	$41,076	$108.83	0.01	$1.09	0.1667	$0.18		
H0022 Intervention Services	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$8.09	$19.00
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.25	$8.23	0.2500	$2.06		
H0048 Alcohol and/or Drug Testing	Laboratory Technician	$49,275	$11,826	$31.33	1.00	$31.33	0.2500	$7.83	$7.83	$18.39
H0049 Alcohol and/or Drug Screening	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$6.86	$16.10
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.10	$3.29	0.2500	$0.82		

Note: ***For presentation purposes, dollar amounts in this table are shown as rounded to the nearest cent, although the actual amounts are carried to multiple decimal places and are used in the specific calculations.***

Service	Staff	Salary	Fringe	Hourly Rate with Productivity Factor Applied	FTE Assigned	Hourly Rate per FTE	Time per Unit of Service (Hours)	Rate per Employee	Total Salary and Fringe per Unit of Service	Total Rate per Unit of Service (Includes 57.4% Administrative and Non-Salary Direct Cost)
H0050 Brief Intervention	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$8.09	$19.00
	Marriage and Family Therapist	$51,792	$12,430	$32.93	0.25	$8.23	0.2500	$2.06		
S5190 Wellness Assessment	Licensed Vocational Nurse	$49,124	$11,790	$31.24	1.00	$31.24	0.7500	$23.43	$31.59	$74.16
	Physician	$171,149	$41,076	$108.83	0.10	$10.88	0.7500	$8.16		
S9075 Smoking Cessation Treatment	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$6.78	$15.92
	Licensed Counselor	$46,953	$11,269	$29.86	0.10	$2.99	0.2500	$0.75		
T1007 Treatment Plan Development/ Modification	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$6.78	$15.92
	Licensed Counselor	$46,953	$11,269	$29.86	0.10	$2.99	0.2500	$0.75		
T1012 Skills Development	Registered/Certified Counselor	$37,960	$9,110	$24.14	1.00	$24.14	0.2500	$6.03	$6.78	$15.92
	Licensed Counselor	$46,953	$11,269	$29.86	0.10	$2.99	0.2500	$0.75		

Note: ***For presentation purposes, dollar amounts in this table are shown as rounded to the nearest cent, although the actual amounts are carried to multiple decimal places and are used in the specific calculations.***

Current Procedural Terminology (CPT) Coding

Service codes for physical exams and Naltrexone injections have established rates through both Medicare and Medicaid programs. The MGT team defaulted to the Medicare rate for these codes as outlined in the table below.

Service	Rate
99203 Physical Evaluation/Exam (30 min)	$114.50
99204 Physical Evaluation/Exam (45 min)	$174.33
99205 Physical Evaluation/Exam (60 min)	$216.35
J2315 Naltrexone per mg	$2.83

Following the description of the residential rates, there is a comparison of the SAPC calculated rates for all HCPCS and CPT codes to other payer types, including Medicare and Medi-Cal.

4: RESIDENTIAL RATE SETTING

The MGT team performed a detailed analysis of SAPC Residential Services to define the appropriate staffing model for long term Residential Treatment. Peer model programs were identified in Florida, Massachusetts, and Nebraska for comparison purposes. The MGT team also relied on the Coopers and Lybrand 1988 study of the SAPC system to identify the base staffing model for Residential Treatment services. Peer state programs were selected because they were mostly funded by state or local substance abuse agencies, had available financial, staffing, and utilization data, and ran similar programs to SAPC. The main goal of capturing similar peer facilities was to identify a consistent staffing model for direct care costs. The MGT team worked with the updated SAPC Standards of Care to group the direct care staff into five discrete categories. Those categories are summarized below.

SAPC Service Definition Standards—Staffing	Education/Experience
Program Manager	Master's or Bachelor's Degree in Business or Related Field
Licensed Physician	See Standards of Care Definition
Licensed Psychologist/Mental Health Therapist	See Standards of Care Definition
Licensed Clinical Social Worker (LCSW)	Master's Degree (Licensed Social Worker)
Substance Abuse Counselors	See Standards of Care Definition

A trend emerged as we looked across state programs regarding the staffing model for substance abuse residential treatment. Essentially every program reviewed had a 0.25 Direct Service FTE-to-bed ratio. This ratio was even consistent with the 1988 Coopers Lybrand SAPC rate report analysis of the Residential Treatment program (0.31 Ratio). The low variability in the direct service-staffing ratio across the MGT team's analysis of multiple states and providers demonstrates a consistent staffing model

approach for rate-setting purposes. The analysis below outlines our study methods, analysis, and final rates for Residential Treatment services.

For the Florida facilities, the MGT team utilized the "Agency Capacity Reports" filed with the Department of Children and Families and used these reports to collect detailed cost data. For the Massachusetts facilities, the MGT team pulled down each facility's Uniform Financial Reports (UFR), the set of financial statements and schedules required of human and social service organizations who deliver services via contracts with state departments.

Massachusetts Substance Abuse Providers

- **Hope House, Inc.**—Hope House, Inc. is a non-profit residential treatment facility located in Boston, MA which is 84% funded by a state substance abuse agency, the Massachusetts Bureau of Substance Abuse Services (BSAS) under the Department of Public Health. It provides residential treatment for male substance abusers. Hope House has an 80-bed capacity, and the length of stay is approximately four-to-six months depending on client need.
- **North Cottage**—North Cottage, Inc. is a non-profit residential treatment facility and Halfway House located in Massachusetts. It operates a 42-bed Intensive Treatment Program (ITP), which provides short-term residential treatment; the average length of stay is 60 days. North Cottage also operates a 71-bed Halfway House that provides long-term residential treatment. Clients can reside here a maximum of 180 days and have already completed a short-term residential program. Additionally, North Cottage has a 21-bed Multi-Phase unit that provides treatment to clients in both the ITP and Halfway House phases.
- **Victory Programs, Inc.**—Victory Programs, Inc. is a Boston, Massachusetts-based non-profit organization that provides care to individuals and families with specialized needs, including those suffering from substance abuse. Victory Programs operates New Victories, a residential treatment program for men with co-occurring health issues, such as mental illness or HIV/AIDS. Victory Program also operates Victory House, another four-to-eight month residential treatment program for men. Combined, these two programs have a total capacity of 49 clients. Victory residential programs are 90% funded through Massachusetts BSAS.
- **Baystate**—Baystate Medical Center, a large for-profit hospital based in Springfield, Massachusetts, contracts through BSAS to provide residential substance abuse treatment. They are 94% funded through BSAS. The Opportunity House is a 38-bed, men-only facility located in Springfield, Massachusetts. The program provides a structured environment and case management for its residents.

Florida Substance Abuse Providers

- **Henderson Mental Health Center**—Henderson Mental Health Center is a private, non-profit behavioral health care system based in Fort Lauderdale, Florida. It treats men and women with co-occurring mental health and substance abuse problems.
    - **Level III Residential Treatment**—Henderson Mental Health Center provides Level III Residential Treatment at The Summit, a group of supervised apartments. The services

provide a training ground for residents to strengthen their living skills. Most residents move into permanent housing in the community after 12 months.

- **House of Hope**—House of Hope & Stepping Stones is non-profit, Department of Children and Families-licensed Level II residential facility located in Fort. Lauderdale, Florida. It treats both men and women suffering from substance abuse and co-occurring disorders. Eight gender-specific buildings provide residential treatment to 92 men and 32 women, for a total capacity of 124 clients; of these, 53 beds are designated for the Department of Corrections six-month treatment program. Additionally, 28 beds are available for transitional housing. House of Hope residential programs appear to be 100% funded by the state and local dollars.

Nebraska Substance Abuse Providers

Nebraska Health and Human Services (HHS) publishes minimum staffing criteria for Intermediate Residential Treatment based on the *"Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R)."* The definition states that, "Intermediate Residential Treatment is intended for adults with a primary Axis I diagnosis of substance dependence for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of dependence on the individual's life or because of a history of repeated short-term or less restrictive treatment failures." Typically, this service is more supportive than therapeutic communities and relies less on peer dynamics in its treatment approach. Individuals are housed in, or affiliated with, permanent facilities where they can reside safely. Level III.3 programs provide structured recovery environment of no more than 16 beds in combination with medium intensity clinical services to support recovery from substance-related disorders.

Nebraska HHS has identified the following minimum staffing ratios for this long-term Intermediate Residential Treatment facility, as defined in the HHS manual.[31]

- Clinical Director to direct care staff ratio as needed to meet all responsibilities.
- 1:10 Direct Care staff to individual served during awake hours (2 shifts, 1.6 FTEs per shift).
- One awake staff for each 10 individuals during client sleep hours (overnight) with on-call availability for emergencies, 2 awake staff overnight for 11 or more individuals served (2 FTEs for a 16 bed Intensive Residential Treatment (IRT) facility).
- On-call availability of medical and direct care staff and licensed clinicians to meet the needs of individuals served 24/7.

[31] State of Nebraska, Department of Health and Human Services. "LEVEL III.3 SA: INTERMEDIATE RESIDENTIAL TREATMENT-Adult (DUAL DIAGNOSIS CAPABLE). Accessed 16 May 2011. <http://www.hhs.state.ne.us/med/intermediate.pdf>

Coopers and Lybrand

The MGT team also reviewed the 1988 Coopers and Lybrand SAPC rate report on Residential Treatment. The report outlined a standard rate-setting methodology that is used regularly by states looking to develop rates for health and human service programs. It was based on "staff fidelity" for services. In order to develop unit cost rates for Residential Treatment, Coopers and Lybrand had to take the following steps:

- Establish minimum standards.
- Establish minimum qualifications for direct care staff.
- Develop minimum counselor-to-client ratios.
- Develop frequency and the staff qualifications needed to provide specific services.

Coopers and Lybrand also developed and conducted an on-site survey to derive an indication of the typical staff composition. For each SPA, the average salary levels and average percentage contributions to total cost were collected. Utilization was estimated based on service frequency requirements, input from SAPC, and an assumption of 90% capacity.

Residential treatment program staffing models were developed with a minimum of 40 clients and a counselor-to-client ratio of 1:8. Unit costs were then summarized for basic and enhanced programs. The enhanced salaries assumed a 20% increase in counselor salaries.

Conclusion

The MGT team canvassed the country in an effort to define the standard staffing ratio for long-term Residential Substance Abuse Treatment. Our analysis of providers in Massachusetts, Nebraska, and Florida identified a clear trend in the level of staffing per occupied bed of 0.29 FTEs with a standard deviation of 0.04.

SAPC Service Definition Standards	State	Program Manager	Licensed Physician	Licensed Psychologist/ Mental Health Therapist	LCSW	Substance Abuse Counselors	Total	Licensed Beds	FTE's Per Occupied Bed
Coopers & Lybrand Report (1988)	CA	0.60	0.60	1.00	1.00	9.00	12.2	40.0	0.31
Victory Program—New Victories	MA	3.20	0.00	0.00	0.00	11.80	15.0	49.0	0.31
Victory Program—Sheppard House	MA	1.60	0.00	0.00	0.00	8.70	10.3	32.0	0.32
Hope House Hope House	MA	1.00	0.00	0.00	0.00	21.32	22.3	80.0	0.28
North Cottage—Recovery House	MA	0.17	0.00	0.00	1.06	34.80	36.0	129.4	0.28
Baystate—Opportunity House	MA	0.00	0.00	0.00	0.00	10.05	10.1	38.0	0.26
Baystate—My Sister House	MA	0.00	0.02	0.00	0.00	6.91	6.9	23.8	0.29
Nebraska HHS—SA Standards for IRT	NE	1.00	0.00	0.00	0.00	5.20	6.2	16.0	0.39
Henderson—III	FL	0.25	0.00	0.00	0.03	1.00	1.3	5.0	0.26
Total FTEs		**7.82**	**0.62**	**1.00**	**2.09**	**108.78**	**120.3**	**413.2**	**0.29**
						Standard Deviation		0.04	

The MGT team used this data to develop a cost per day for Residential Treatment services. The direct service FTE ratio is consistent with the sample of providers reviewed across the country and the 1988 rate report. The MGT team has utilized this staffing mix to develop the minimum staffing standard cost per day calculation. The calculation is based on 40 licensed beds and average salaries from the Bureau of Labor Statistics. A fringe benefit rate of 25.90% was also used based on the average fringe for SAPC Residential Providers.

SAPC Service Definition Standards	Program Manager (BLS)	Licensed Physician (BLS)	Licensed Psychologist/ Mental Health Therapist (BLS)	LCSW (BLS)	Substance Abuse Counselors (BLS)	Total
Standard Program FTE's per 40 Beds	0.76	0.06	0.10	0.20	10.53	11.65
Average Hourly Rate	$46.68	$82.28	$34.29	$23.24	$18.25	
FTE Hours Per Year	2,080	2,080	2,080	2,080	2,080	
Salary Estimate	$73,489	$10,271	$6,903	$9,758	$399,706	$500,127
Licensed Days per Year (40 Beds)	14,600	14,600	14,600	14,600	14,600	14,600
Salary Cost Per Day						**$34.26**
Fringe Rate From 2009-2010 SAPC Residential Providers						**25.90%**
Salary and Fringe Cost Per Day						**$43.13**

The MGT team then calculated the standard Room and Board (R&B) rates utilizing the SAPC cost reports to identify the Fixed (and Other Direct) Rate and Administrative Rate. The rates will be billed under a separate code for Residential R&B only.

	Fixed and Other Direct Rate	Administrative Rate	Total R&B Rate
	$38.07	$32.64	$70.71

Residential Impact Analysis

The MGT team analyzed the impact of updating Residential Rates based on these recommendations. The table below outlines the old and new rates, variance, and cost impact to SAPC if they move to the new rate schedule. Assuming the same volume/utilization, the rate change would decrease SAPC's cost by about $900,000. Some SPA's would see minimal increases or decreases (SPA 6 with $4.85 per day increase) and others would see large increases or decreases (SPA 2 with a $106.15 per day decrease).

Description	SPA 1	SPA 2	SPA 3	SPA 4	SPA 5	SPA 6	SPA 7	SPA 8	Weighted Average
Fixed Rate Per Day	$38.07	$38.07	$38.07	$38.07	$38.07	$38.07	$38.07	$38.07	$38.07
Administrative Rate Per Day	$32.64	$32.64	$32.64	$32.64	$32.64	$32.64	$32.64	$32.64	$32.64
Treatment Rate Per Day	$40.14	$40.14	$40.14	$40.14	$40.14	$40.14	$40.14	$40.14	$40.14
Updated Rate Per Day	**$110.85**	**$110.85**	**$110.85**	**$110.85**	**$110.85**	**$110.85**	**$110.85**	**$110.85**	**$110.85**
2009-2010 Average Rate Per Day	*$161*	*$217*	*$115*	*$78*	*$135*	*$106*	*$146*	*$118*	*$114*
Variance	**($50.15)**	**($106.15)**	**($4.15)**	**$32.85**	**($24.15)**	**$4.85**	**($35.15)**	**($7.15)**	**($3.15)**
2009 –2010 Total Days	6,876	16,857	52,296	82,263	7,834	50,659	28,917	42,459	288,161
Cost Impact	**($344,831)**	**($1,789,371)**	**($217,028)**	**$2,702,340**	**($189,191)**	**$245,696**	**($1,016,433)**	**($303,581)**	**($907,707)**

Note: Some of the individual totals in this table differ by $1 due to rounding.

In the above table, the MGT team is projecting that some SPAs will experience a positive financial impact as a result of the new service rates. Specifically, some SPAs will receive more money from SAPC because of the change in the reimbursement methodology. However, the MGT team also projects that there will be some SPAs that will be negatively impacted by the new service rates.

It is important to note that the above analysis is at the SPA level and not at the provider level. There may be individual providers within each SPA that may be positively or negatively impacted overall by the change in service rates. It is unknown at this time what the outcomes will be for each provider under the new reimbursement methodology.

Residential Short Term/Residential Long Term*:* The cost report information we had access to did not provide enough details to determine if cost differences existed between long- and short-term providers. The rates provided above, reflect the MGT team's recommendation for a standard base rate. Any adjustments would be accounted for using modifiers in the new reimbursement system.

5: SUB-ACUTE DETOXIFICATION (MEDICALLY OR CLINICALLY MONITORED) RATE SETTING

There are currently two providers with a total of four SAPC contracts that qualify to bill under the recommended sub-acute detoxification (medically or clinically monitored) rate categories—Behavioral Health Services (BHS) and Tarzana Treatment Services. Similar to residential treatment services, the MGT team researched comparable programs in various states in order to assist in the rate setting exercise.

Massachusetts Detoxification Providers

- **Bay Cove**—Bay Cove Human Services is a private, non-profit provider of substance abuse services located in Boston, Massachusetts. It operates two detoxification facilities:
  - **Andrew House**—Andrew House is an intensive-care detoxification center serving dual-diagnosed or dually-addicted males and females in North Quincy, Massachusetts, at the Long Island Hospital Campus. Clients generally stay from 5 to 9 days, and treatment includes assessment, counseling, case management, and medically-managed detoxification, in some cases. Andrew House has the capacity to serve 30 clients.
  - **Bridge to Recovery -** Bridge to Recovery is an acute detoxification center located in North Quincy at the Long Island Hospital Campus. The center has the capacity to serve 22 men and 8 women in two gender-specific units. Treatment is provided according to each client's individualized treatment plan.
- **CAB Health & Recovery Services, Inc.**—CAB Health and Recovery Services is a non-profit provider of substance abuse services with locations in the greater Boston area. It operates two detoxification centers in Danvers and Boston. These centers have the capacity to provide medical detoxification to 100 clients.
- **Community Healthlink, Inc.**—Community Healthlink, Inc. is a private, non-profit organization located in Worcester. It operates a two-week inpatient detoxification program for homeless adults and other substance abusers. The unit has a 43-bed capacity.
- **Dimock Community Foundation, Inc.**—The Dimock Center is a non-profit health and human services organization serving the greater Boston area. Dimock operates a 30-bed detoxification facility in Roxbury that provides acute treatment services.

Florida Detoxification Providers

- **Memorial Regional Hospital (South Broward Hospital District)—**Memorial Regional Hospital provides inpatient detoxification for adults (11-bed capacity). During this stage, clients are assessed for co-occurring mental health issues before being stepped down to intensive outpatient services.

The chart on the following page shows a detailed comparison of various operating ratios for the inpatient detoxification programs.

	Bay Cove—Andrew House	Bay Cove - Bridge to Recovery	CAB Health & Recovery Services, Inc.	Community Healthlink, Inc.	Dimock Community Foundation, Inc.	South Broward Hospital District
Cost Data						
Cost per Bed Day	$226.27	$200.40	$217.02	$212.17	$197.08	$248.75
Direct Service Personnel Cost	$109.28	$102.34	$98.65	$107.07	$94.34	$109.84
Program Support Staff Cost	$9.02	$10.47	$14.84	$9.83	$11.20	$0.00
Fringe Cost	$20.91	$19.90	$24.94	$23.34	$19.53	$20.65
Other Non-Fixed, Non-Administrative Costs	$65.04	$48.02	$48.92	$52.12	$21.06	$87.81
Administrative Cost	$22.02	$19.67	$29.67	$19.80	$50.96	$30.45
Direct Service Personnel Cost	48%	51%	45%	50%	48%	44%
Program Support Staff Cost	4%	5%	7%	5%	6%	0%
Fringe Cost	9%	10%	11%	11%	10%	8%
Other Non-Fixed, Non-Administrative Costs	29%	24%	23%	25%	11%	35%
Administrative Cost	10%	10%	14%	9%	26%	12%
	100%	100%	100%	100%	100%	100%

Note: Some of the individual totals in this table differ by $0.01 or 1% due to rounding.

As shown above, the majority of the each program's costs are attributable to direct service staff costs. Similarly, each of BHS' and Tarzana's program costs predominantly consist of direct service staff related expenses. However, given the nature of the services provided in a residential detoxification setting, it is not possible to compare the peer programs to BHS and Tarzana programs. Each program is operated with a varying level and complement of staff.

Given the lack of comparable data, the MGT team recommends that rates for residential detoxification be based on the respective providers' filed cost reports. The MGT team recommends that SAPC continue to work with these providers to understand how their residential detoxification services are provided and by what types of staff. SAPC should monitor the costs of these programs on an annual basis.

The recommended rate for these services is reported cost, based on the filed cost reports. The calculated rates for each contract are as follows:

Agency	Contract #	Rate per Day
BHS ARC	H-801603E	$300.53
BHS RGM	H-801603B	$349.87
Tarzana 1	H-702267B	$381.35
Tarzana 2	PH-000918D	$368.62

The recommended rate per day for each contract can be broken down by direct staffing and fringe costs, fixed costs, and administrative costs, as summarized in the table below. Although similar categories are identified on the preceding page for programs in other states, the differences in the nature of services provided and the method of service delivery result in variances in the rates.

Cost Component	BHS ARC	BHS RGM	Tarzana 1	Tarzana 2
Direct Service Staffing Cost per Day	$148.60	$171.38	$162.67	$157.20
Fixed Cost Per Day	$77.22	$87.36	$68.86	$66.55
Administrative Cost Per Day	$74.70	$91.12	$149.81	$144.87
Total Rate Per Day	$300.53	$349.87	$381.35	$368.62

Potential Rate Modifiers

The cost report data analysis performed by the MGT team provides SAPC and its contracting providers with an in-depth look at the comparison of costs between each of the SPAs and each of the modalities. In order to best set appropriate rates, it is critical to have an understanding of where any variation in costs may exist among providers, SPAs, or modalities. In the following section, MGT summarizes how each of a number of factors can impact the rates and whether or not the impact requires a rate modifier.

As part of the cost analysis to be performed under the adult outpatient and residential substance abuse services rate study, the MGT team considered the impact of several cost adjustment factors on potential rates, including the following:

- Level of Intensity of Services
- Poverty
- Unemployment
- HIV/AIDS Populations
- Lesbian, Gay, Bisexual, And Transgender Populations
- Co-Occurring Substance Abuse/Mental Health (SA/MH) Disorder Population
- Female Population
- Monolingual Population
- Drug Court Population
- Real Estate Values and Rent Costs
- Wage Levels
- Size of Providers
- License Requirements
- Staff Requirements and Credentials
- Impact of Health Care Reform

Some of the measures reviewed have a caseload impact rather than a per-unit cost impact. Those measures that are identified as having a per-unit cost impact may coincide with the recommendation of a rate modifier. However, those measures that are not seen as having a per-unit cost impact will not have a modifier recommendation. For example, the rate of unemployment and poverty in a geographic area will increase the total number of clients seeking services in that area while not necessarily increasing the cost per client. Other measures, such as variations in staff credentials across providers, will directly affect the cost per unit of service. The section that follows will provide discussion and support for each measure and the recommended rate modifiers, if applicable.

Level of Intensity of Services

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Level of Intensity of Services	☑		

The level of intensity of services would potentially have an impact on the per-unit cost of providing services. However, SAPC does not currently have a standard assessment tool that scores each provider type by the level of intensity or acuity of their patients. Furthermore, SAPC does not have a standard tool that scores each individual by level of intensity, also known as acuity, across all providers. If SAPC wishes to introduce an intensity score to rate setting, they may consider developing a single reporting tool for both providers and individuals. An acuity tool could then be combined with provider rate-setting data to create an acuity adjusted provider rate. SAPC may also consider developing individual budgets based on acuity. A system like this would require considerable resources to implement. As such, the MGT team would suggest SAPC pursue this as a long-term strategy effort.

Rate modifier code: Not required at this time.

Poverty

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Poverty		☑	☑

Poverty issues will have an impact on the caseload for the provider network and that impact will vary by SPA. The SAMHSA discusses the increased need for substance abuse treatment services among people living in poverty in their report, National Survey on Drug Use and Health.[32] According to that report, 12.3% of people living in poverty are in need of substance abuse treatment services. Of this population, males ages 18-to-25 are the most likely to have a need for treatment services.

To better serve and plan for the citizens of Los Angeles County, the County Department of Public Health is divided into eight SPAs to coordinate services and programs. The SPAs are: Antelope Valley, San Fernando, San Gabriel, Metro, West, South, East, and South Bay. Below is a map of the LA County SPAs.

[32] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The NSDUH Report: Substance Use Treatment Need and Receipt among People Living in Poverty.* Rockville, MD. January 14, 2010.

As a County, 16% of the population has income less than 100% of the Federal Poverty Level (FPL). The SPAs above the county average (16%) are: Antelope Valley (18%), Metro (23.8%), and South, with the largest percentage of 28.3%. The SPAs with the lowest poverty levels are: West (10.3%), San Fernando (12%), and San Gabriel (12.4%). It is possible, based on the SAMSHA report that Antelope Valley, Metro, and South SPA providers see a higher caseload of substance abuse clients due to the higher rate of poverty compared to the other SPAs.

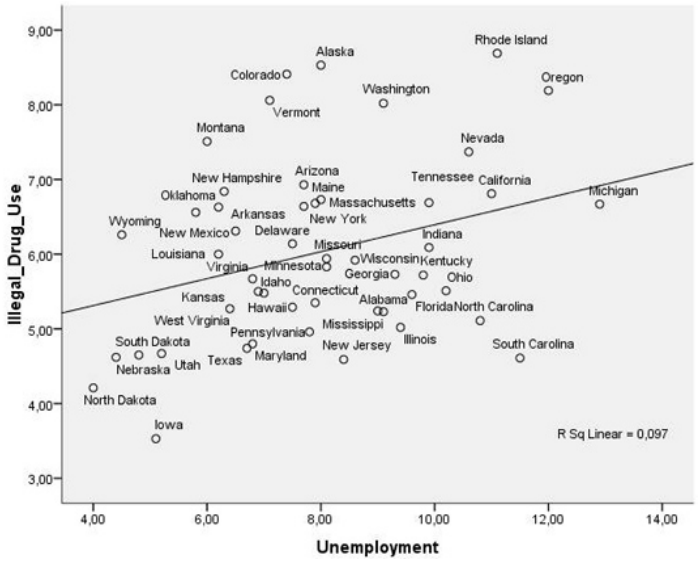
Rate modifier code: Not required.

Unemployment

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Unemployment		☑	☑

Similar to poverty, unemployment will have an impact on the caseload for the provider network and that impact will vary by SPA. The United States' economy was slowed by a severe recession combined with a staggering financial crisis in 2008 and 2009. Unemployment rates skyrocketed during this period as jobless rates increased across almost every state. This rise in unemployment has sustained itself through the last three years and remains a significant issue to consider when examining the rates for providing substance abuse services. The unemployment rate in California has been steadily higher than the unemployment rate across the country.

Unemployment issues within each SPA area will have an impact on the caseload for the provider network. The following chart shows the correlation of the rise of unemployment with the increase of illegal drug use.[33] With an increased unemployment rate, it is therefore assumed that there are larger amount of caseloads for substance abuse providers.



The unemployment rate for Los Angeles County averaged about 12.7% for 2010, according to the state of California Employment Development Department.[34] Within the county, the following chart shows the top 10 places with the highest unemployment rate along with their associated SPA.

Area Name	*Unemployment Rate*	*SPA*
Los Angeles County	12.7%	
Florence Graham CDP*	24.7%	6
Westmont CDP*	24.6%	8
Commerce City	23.4%	7
East Compton CDP*	22.4%	6
Industry City	22.3%	3

Continued

[33] "Does Higher Unemployment Lead to More Drug Use?." The New York Times 12 Aug. 2009. Accessed 16 May 2011. <http://economix.blogs.nytimes.com/2009/08/12/does-higher-unemployment-lead-to-more-drug-use/>

[34] State of California, Employment Development Department. "REPORT 400 C Monthly Labor Force Data for Counties Annual Average 2010—Revised." 3 March 2010. Accessed 16 May 2011. < http://www.calmis.ca.gov/file/lfhist/10aacou.pdf>

Area Name	Unemployment Rate	SPA
Compton City	21.2%	6
Willowbrook CDP*	20.7%	6
West Compton CDP*	20.4%	6
Bell Gardens City	19.9%	7

**Census Designated Place*

Similar to the poverty factor, it is possible, that the SPAs with the highest unemployment rates may see a higher caseload of substance abuse clients as compared to the other SPAs.

Rate modifier code: Not required.

Real Estate Values and Rent Costs

Measure	Per-unit Cost Impact	Caseload Impact	SPA Impact
Real Estate Values and Rent Costs	☑		☑

Real estate values and rent costs will certainly have an impact on the per-unit cost of providing services. Market conditions for Los Angeles commercial real estate has steadily declined since 2008. Despite this, commercial real estate in Los Angeles has not declined nearly as bad as other major cities in the United States due to its well-diversified tenant base. Relatively high rental rates across Los Angeles will impact substance abuse facilities. Real estate values and rental costs impact the cost of providing service. The higher the lease or mortgage, the higher the indirect cost will be. However, the indirect cost of real estate and rent is included on each provider's cost report. The MGT team has included an indirect (non-salary direct cost) factor in the recommendations for both the outpatient and inpatient service rates. Therefore, no modifier is necessary.

Rate modifier code: Not required, as explained above.

Wage Levels

Measure	Per-unit Cost Impact	Caseload Impact	SPA Impact
Wage Levels	☑		☑

Substance abuse treatment centers are health care providers that rely heavily on human labor to provide services. Due to the nature of the services provided, employee wages are one of the biggest cost drivers for these providers. Providers must pay for qualified health care professionals to provide such services. Differences in wage levels can vary between SPAs and therefore, some providers might see higher wage costs than others.

The following table, Table 4, provides average hourly wages for service types for four census areas in or near Los Angeles County. From this table, it is possible to assume the differences between areas and wages.

Table 4. Average Salaries by MSA

Average Salaries by MSA in or near LA County				
Job Title	***Long Beach-Glendale[35]***	***Santa Ana - Anaheim[36]***	***Oxnard–Thousand Oaks[37]***	***Riverside–San Bernardino[38]***
Psychiatrist	**$72.98/Hr**	**$72.91/Hr**	**N/A**	**$100.96/Hr**
Marriage and Family Therapist (MFT)	**$24.18/Hr**	**$24.19/Hr**	**$25.47/Hr**	**$25.76/Hr**
Psychologist	**$43.67/Hr**	**N/A**	**N/A**	**N/A**
Medical and Health Services Manager	**$47.92/Hr**	**$47.29/Hr**	**$44.89/Hr**	**$46.60/Hr**
Registered Nurse	**$38.99/Hr**	**$36.73/Hr**	**$37.05/Hr**	**$36.45/Hr**
Licensed Practical Nurse	**$23.11/Hr**	**$24.41/Hr**	**$25.64/Hr**	**$21.31/Hr**
Mental Health and Substance Abuse Social Workers	**$21.80/Hr**	**$22.65/Hr**	**$26.92/Hr**	**$21.59/Hr**
Substance Abuse and Behavioral Disorder Counselors	**$16.08/Hr**	**$16.36/Hr**	**$18.64/Hr**	**$21.92/Hr**
Mental Health Counselor	**$22.59/Hr**	**$18.52/Hr**	**N/A**	**$26.61/Hr**

However, the MGT team was unable to verify these differences in salary by SPAs using cost report data. Therefore, the MGT team recommended that SAPC continue to improve data collection on the cost reports in order to determine if modifiers based on SPA are warranted at some point in the future.

Rate modifier code: Not required at this time.

35 Bureau of Labor Statistics. "May 2009 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates Los Angeles-Long Beach-Glendale, CA Metropolitan Division." Accessed 16 May 2011. <http://www.bls.gov/oes/current/oes_31084.htm>

36 Bureau of Labor Statistics. "May 2009 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates Santa Ana-Anaheim-Irvine, CA Metropolitan Division." Accessed 16 May 2011. <http://www.bls.gov/oes/current/oes_42044.htm#19-0000>

37 Bureau of Labor Statistics. "May 2009 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates Oxnard-Thousand Oaks-Ventura, CA." Accessed 16 May 2011. <http://www.bls.gov/oes/current/oes_37100.htm#11-0000>

38 Bureau of Labor Statistics. "May 2009 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates Riverside-San Bernardino-Ontario, CA." Accessed 16 May 2011. <http://www.bls.gov/oes/current/oes_40140.htm#11-0000>

Size of Outpatient and Residential Care Providers

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Size of Outpatient and Residential Care Providers	☑		

As the size of the provider increases, the MGT team expected that the cost per unit would decrease to account for economies of scale among larger providers. The MGT team considered the SAPC proposed provider size definitions for Adult Outpatient, Adult Residential, Unlicensed Drug and Alcohol Free Living Centers, and Unlicensed Satellite Housing. The proposed slot and bed requirements are consistent with peer states or counties definitions across the country.

Service Category	*Small*	*Medium*	*Large*
Adult Outpatient	1 to 30 Slots	31 to 50 Slots	51 or More Slots
Adult Residential	15 Beds or Less	16 to 100 Beds	101 Beds or More
Unlicensed Drug and Alcohol Free Living Centers	Limited to 6 Individuals	Not Applicable	Not Applicable
Unlicensed Satellite Housing	Limited to 6 Individuals	Not Applicable	Not Applicable

The expectation that the cost per unit of service would decrease to account for economies of scale among larger providers holds true when comparing small to medium size providers in the table below. However, the theory did not hold up as we compared the medium to large providers. The severe rate changes between small to medium and medium to large indicate that there is lack of uniform contracting standards across the different residential provider sizes.

Anecdotal data collected from Behavioral Health Services (BHS) during the December 2010 focus group sessions suggest that the provider's per-unit cost is largely affected by the credentials of their staff, which includes physicians, psychiatrists, and master's level social workers. Additionally, BHS facilities are equipped to handle near acute detoxification, which may drive up their overhead costs. Because of this inconsistency in the data the MGT team does not recommend that SAPC develop specific rates based on the size of the providers. However, a distinction in the rates for small, medium, and large providers may be implemented in future rate years. The data to support such differences in costs must be improved.

Cost Category	*Small*	*Medium*	*Large*
Salary	$54.58	$39.45	$52.97
Benefit	$13.48	$9.65	$18.84
Facility Rent Lease of Depreciation	$9.20	$5.10	$6.96
Equipment and Other Assets	$1.37	$0.61	$1.12
Other Direct Costs	$32.64	$23.27	$33.80
Equipment Depreciation	$2.46	$1.94	$1.27
Administrative Overhead (1)	$9.72	$6.93	$13.40
Administrative Overhead (2)	$10.31	$0.54	$2.12
Administrative Overhead (3)	$2.46	$2.93	$5.02
Total Cost Per Day	**$136.23**	**$90.42**	**$135.51**

Rate modifier code: Not required at this time.

Special Populations

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Special Populations	☑		

Subsets of SAPC providers administer programs that are directly targeted toward specific populations, including pregnant women and mothers, HIV positive individuals, individuals undergoing court-ordered treatment, and the indigent population. Specialized treatment programs, supplemental staff training, and higher case management activity costs are just a few examples of the expected increase in unit costs associated with serving these populations.

The current cost report includes information on the targeted populations for each provider. An initial analysis of this data suggests that those programs targeted to pregnant women and mothers have an higher average residential unit cost than all other programs studied. However, the data provided represents only those populations that are *targeted*. Therefore, there is the strong potential that programs serving the general population also accommodate special populations to varying degrees. By incorporating the use of modifiers, both "general population" and "targeted population" providers can more appropriately capture the additional costs associated with serving these individuals on a case-by-case basis.

Rate modifier code: Rate modifier code is required.

Population Modifiers

As described previously, the treatment of certain populations has proven more costly than treating the general population. Populations with expected per-unit cost increases include:

- Individuals with co-occurring mental health disorders;
- Pregnant and parenting women;
- Court-ordered participants;
- Monolingual individuals; and,
- Homeless individuals.

A portion of the increased costs associated with treating these individuals can be attributed to the requirement of more highly qualified staff. Providers can account for these costs by using staffing modifiers as described above. There are also, however, additional administrative costs associated with treatment. For example, there is an administrative burden associated with maintaining client contact when treating the homeless population or completing additional paperwork for court-ordered treatment. To account for these costs, a 10% increase may be applied to the base rate for these populations.

Population Modifiers	*Population Served*	*Modified Rate*
(none)	General Population	See Fee Schedule
HH	Co-Occurring Mental Health Disorders	See Fee Schedule
HD	Pregnant/Parenting Women	See Fee Schedule
H9	Court Ordered	See Fee Schedule
HL	Monolingual	See Fee Schedule
HI	Homeless	See Fee Schedule

License Requirements

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
License Requirements	☑		

Licensing and certification for substance abuse facilities is governed by ADP. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or alcoholism or drug abuse recovery or treatment planning.[39] In addition to facility licensure, ADP provides a voluntary facility certification process to identify those programs which exceed minimum levels of service quality and are in substantial compliance with State program standards. Certification is available to both residential and nonresidential programs.

Additionally, providers can choose to be accredited by the CARF, the Joint Commission, Council on Accreditation of Children and Family Services (COA), or National Committee for Quality Assurance (NCQA). A 2004 study by the Institute for Behavioral Research (University of Georgia) provides a

[39] www.adp.ca.gov. Accessed 16 May 2011. <http://www.adp.ca.gov/Licensing/licensing.shtml>

breakdown of accreditation standards for 362 publicly funded substance abuse treatment centers. Thirteen percent (13%) were accredited by the Joint Commission, 15.6% were accredited by CARF, and nearly 2% of the providers were accredited by both organizations. About 72% of the centers did not hold either accreditation.

For many facilities, cost factors into the decision about which accreditation to pursue. That cost comes from having the staff and the processes in place to maintain a safe environment for patients. Organizations need to budget for the price of survey preparation. The MGT team was able to make estimates based on review of materials and interviews with accreditation providers. The annual estimate is as follows:

- **Joint Commission**—Annual fees are based on the size and the service complexity of individual facility and range from $1,780 to $36,845. For 2008, the on-site survey fees for facilities are: $2,500 per surveyor for the first day, and $1,030 per surveyor for the second and subsequent days.

- **CARF**—Standards Manual: $150; Application/Intent to Survey: $925; Surveyor per day: $1,325. MGT estimates the average cost would be less than $5,000 per year.

- **COA—Non-Refundable First time Application fee: $750**; Accreditation fee based on a sliding scale of organizations' audited gross annual revenue. Fees start at $6,270 for providers with $500,000 income or less, and increase from that point. On-Site Review: $2,000 flat per surveyor for two-day period, plus $425 add-on per reviewer, per additional day. Annual Maintenance fee of $400. MGT estimated the average annual cost at $10,000 per year based on these requirements.

- **NCQA—Standards and Guidelines**: $235 to $260; Application for Survey: free; Survey Cost: Negotiated with NCQA after discussion of which programs will be surveyed. MGT estimated the average annual cost at $5,000 per year based on these requirements.

The MGT team also researched for detailed summaries on the accreditation maintenance cost comparisons of JCAHO, CARF, COA, or NCQA accreditation. However, the MGT team was unable to identify any studies.

Rate modifier code: Not required. Providers are not required to pursue licensure above and beyond the State of California certification.

Staff Requirements

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Staff Requirements	☑		☑

Staffing requirements vary by both modality and provider. Some modalities, such as residential treatment, require specific minimum levels of credentialed personnel to staff or provide consultation for the program. The rates assigned account for these modality specific requirements, as all staff costs associated with the program are included on the current cost report.

However, according to the anecdotal data from the December 2010 provider focus groups, there is wide variation in staffing credentials among individual providers. While providers whose staff generally possess high levels of certification, licensure, etc. would be expected to have higher unit costs, the staff title data provided on the cost report does not support a more in-depth analysis of this cost factor at this time. An explanation of this limitation is provided below.

As part of the cost report training presentation, MGT provided a list of 17 position titles to be utilized on schedule P1 of the cost report. After the close of the cost report editing period, there were 834 titles reported. Some titles appear to be erroneous, such as “Accrual Cost of Living” or “Salaries.” Others such as “Recovery Associate” or “Intern,” do not provide enough detail to associate the title with a particular credential. More specifically, while there are three levels of credentialing for substance abuse counselors, the majority of “Counselor” entries in the cost report do not specify whether the counselor is registered, certified, or licensed.

Additionally, according to the submitted position titles, none of the cost reports include costs for physicians or psychiatrists. Given the level of care provided at some residential treatment and detoxification centers and the anecdotal data collected during the focus groups, one would expect to see some level of cost data for these types of providers within the cost reports. Costs for these providers may be included under the “Clinician” or “Specialist” titles, but there is not enough detail in the cost report data to support that assumption.

Under the FFS model, modifiers may be used to capture the difference in cost associated with various provider-credentialing levels. For example, if a licensed Marriage and Family Therapist performs the same service at one provider that a Certified Substance Abuse Counselor performs at another provider, a modifier may be added in order to increase the rate of reimbursement by an appropriate increment. To accommodate the calculation of modifiers in future rate adjustment periods, MGT recommends the use of a predetermined list of position titles on the cost report.

Rate modifier code: Rate modifier code is required.

Staffing Modifiers

To account for the added value associated with employment of more highly qualified staff, the MGT team has designated four staffing modifiers to apply to the non-residential codes. Two modifiers are to be used for the behavioral codes, substituting a Registered/Certified Counselor for either a Licensed Counselor or Marriage and Family Therapist. The remaining two codes are used for the medical codes, substituting an LVN for either and RN or Physician.

Staffing Modifiers	*Provider*	*Modified Rate*
(none)	Minimum Standard	
A1	Primary Service by Licensed Counselor	See Fee Schedule
A2	Primary Service by Marriage and Family Therapist	See Fee Schedule
A3	Primary Service by Registered Nurse	See Fee Schedule
A4	Primary Service by Physician	See Fee Schedule

Impact of Health Care Reform and Access to Healthcare

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Impact of Health Care Reform and Access to Healthcare		☑	☑

Access to healthcare will impact the caseload for each SPA provider network. The South and Metro SPAs have the largest populations in Los Angeles County that are uninsured with 32.9% and 31.4%, respectively. Additionally, adults within both of these communities reported having difficulty accessing medical care.

A recent report by NASADAD found that health reform would expand the demand for substance abuse services.[40] The Patient Protection and Affordable Care Act (PPACA) is estimated to increase insurance coverage by approximately 30 million across the country once fully implemented. This insurance expansion will have an impact on the Los Angeles County SAPC provider network as they work to define the populations and services covered under health reform.

The June 2010 NASADAD report found an increased service demand for substance abuse services after state-initiated health reform was initiated in Massachusetts, Maine, and Vermont over the past five years. Each state was able to increase access to substance abuse treatment through Medicaid expansions, increases in the budget of the state substance abuse provider by the state, process

[40] National Association of State Alcohol and Drug Abuse Directors, Inc. "Effects of State Health Care Reform on Substance Abuse Services in Maine, Massachusetts, and Vermont." June 2010. Accessed 16 May 2011. <http://nasadad.org/resources/June%20NASADAD%20Health%20Reform%20Three%20States%20Final.pdf>

improvement initiatives, and the creation of publicly subsidized, private insurance plans. Even with expansions in coverage, the uninsured rate among those with substance use disorders remained high in the three states.

These changes will impact the Los Angeles SAPC's provider network in a few ways. First, the increased insurance eligibility (both Medicaid and publicly subsidized private insurance) will change the funding mix for SAPC providers. It is not known if this is a positive or negative impact to provider operations as we do not know if the payment rates will support the utilization-driven cost increase. Also, the substance abuse disorder population will have a disproportionately high rate of uninsured when compared to the rest of the population. This issue stresses the need for continued state and federal coverage through the SAMSHA block grant and other sources.

National health care reform will need to be monitored for the Los Angeles SAPC provider network as it will increase the service demand and caseloads of the providers. There is also a possibility that health reform and insurance expansion will bring new administrative costs to providers dealing with new regulations, eligibility, and billing rules. These cost increases will be reflected in annual cost reports so they will be built into the rate-setting calculation. No specific adjustment is recommended at this time. However, Los Angeles SAPC should continue to monitor how health reform impacts caseloads, insurance access, and the administrative cost of providers throughout the SAPC network.

Rate modifier code: Not required.

Lead Agency of a Consortium

Measure	*Per-unit Cost Impact*	*Caseload Impact*	*SPA Impact*
Lead Agency of a Consortium	☑		☑

The lead agency of a consortium is responsible for coordinating and monitoring the service delivery of the consortium providers, maintaining appropriate documentation for the services provided to clients, reporting costs and unit data to SAPC for reporting purposes, and managing the subcontracts with consortium providers. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and CMS recognize that administrative management and oversight responsibilities come at a cost to providers, and as agencies, are willing to pay a reasonable amount for those services. However, both agencies have imposed limitations on administrative costs in several instances.

For example, HRSA imposes an administrative cost limitation of 10% for certain HIV/AIDS program funding. HIV/AIDS Title II grantees are limited to not more than 10% of their grant on administration (Section 2618(b)). In explaining the 10% administrative cost cap, the Joint Explanatory Statement of the Committee on Conference, which accompanies the legislation, it identifies that “entities subject to this cost cap include the lead agencies of consortia in carrying out their administrative duties associated with the operation of the consortium.” While CMS is willing to reimburse reasonable costs for administrative expenditures, it does impose cost limitations for specific programs. The Children’s Health Insurance

Program (CHIP), for example has an administrative cost limitation on expenditures not being used for medical assistance. Sections 2105(c)(2)(A), and 2105(a)(1)(D)(iv) of the SSA state that administrative costs "shall not exceed 10% of the total amount of expenditures."

The MGT team has provided rates in this report that are market based for the services identified in the standards of care report. If SAPC wishes to reimburse consortiums for consortium administrative expense, the MGT Team recommends that SAPC implement a process where providers submit budgets that define the consortium administrative expense discretely from every other general administrative, direct service, and non-allowable cost centers. SAPC should impose a 10% cap on the administrative costs associated with a lead agency of a consortium. To implement this cost limitation, the MGT team recommends that the administrative costs are not paid on a fee schedule, but instead are paid on a quarterly basis through a reimbursement process. Each quarter, the lead agency of the consortium through an invoice or claim, would submit a statement for reimbursement to SAPC not to exceed 10% of the defined base cost pool.

Rate modifier code: Not required. Ten percent of the lead agency's base cost pool should be paid on a quarterly basis. Such a payment would not be claim based.

Recommended Fee Schedule

Based on the descriptions above of outpatient, residential, and modifiers, below is the recommended SAPC fee schedule.

		Staff Modified Rate				Population Modified Rate				
Recommended SAPC Procedure Codes	**Base Rate**	**A1**	**A2**	**A3**	**A4**	**HH**	**HD**	**H9**	**HL**	**HI**
H0001 Assessment	$75.99	$89.42	$96.64			$83.59	$83.59	$83.59	$83.59	$83.59
H0003 Laboratory Analysis	$12.26					$13.48	$13.48	$13.48	$13.48	$13.48
H0004 Individual Counseling	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
H0005 Group Counseling	$4.75	$5.59	$6.04			$5.22	$5.22	$5.22	$5.22	$5.22
H0006 Case Management	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
H0010 Sub-Acute Detoxification (Medically Monitored)	Cost*									
H0012 Sub-Acute Detoxification (Clinically Managed)	Cost*									
H0015 Day Care Habilitative Treatment	$83.39	$100.18	$109.19			$91.73	$91.73	$91.73	$91.73	$91.73
H0016 Medical Intervention in an Ambulatory Setting	$39.20			$49.82		$43.12	$43.12	$43.12	$43.12	$43.12
H0017, H0018, H0019 Residential Treatment Program	$43.13					$47.44	$47.44	$47.44	$47.44	$47.44
H0020 HG, Methadone Administration	$14.58			$21.66	$44.93	$16.04	$16.04	$16.04	$16.04	$16.04
H0022 Intervention Services	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
H0048 Alcohol and/or Drug Testing	$18.39					$20.23	$20.23	$20.23	$20.23	$20.23
H0049 Alcohol and/or Drug Screening	$16.10	$19.46	$21.26			$17.71	$17.71	$17.71	$17.71	$17.71
H0050 Brief Intervention	$19.00	$22.36	$24.16			$20.90	$20.90	$20.90	$20.90	$20.90
J2315 Naltrexone (per mg)	$2.83					$3.11	$3.11	$3.11	$3.11	$3.11
S0281 Medical Home Care Coordination Maintenance	TBD									
S5190 Wellness Assessment	$74.16			$106.03	$210.76	$81.57	$81.57	$81.57	$81.57	$81.57
S9075 Smoking Cessation Treatment	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
S9976 Lodging	negotiated									

Continued

		Staff Modified Rate				Population Modified Rate				
Recommended SAPC Procedure Codes	**Base Rate**	**A1**	**A2**	**A3**	**A4**	**HH**	**HD**	**H9**	**HL**	**HI**
T1007 Treatment Plan Development/Modification	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
T1012 Skills Development	$15.92	$19.28				$17.51	$17.51	$17.51	$17.51	$17.51
99203 Physical Evaluation/Exam (30min)	$114.50					$125.95	$125.95	$125.95	$125.95	$125.95
99204 Physical Evaluation/Exam (45min)	$174.33					$191.76	$191.76	$191.76	$191.76	$191.76
99205 Physical Evaluation/Exam (60min)	$216.35					$237.99	$237.99	$237.99	$237.99	$237.99
X9999 Residential Room and Board	$70.71					$77.78	$77.78	$77.78	$77.78	$77.78

*There are currently only two providers with a total of four SAPC contracts to provide the following services:

H0010 Sub-Acute Detoxification (Medically Monitored)
H0012 Sub-Acute Detoxification (Clinically Managed)

The recommended rate for these services is reported cost, based on the filed cost reports. The calculated rates for each contract are as follows:

Agency	Contract #	Rate per Day
BHS ARC	H-801603E	$300.53
BHS RGM	H-801603B	$349.87
Tarzana 1	H-702267B	$381.35
Tarzana 2	PH-000918D	$368.62

There are a number of recommended fees for which the MGT team was able to find comparable service rates for different payers, such as Medicare, Medi-Cal, and other state Medicaid programs. Overall, the recommended rates for SAPC are in line with the comparable rates, which are summarized below.

HCPCS/ CPT Code	Service Name	Medicare	Medi-Cal	BC/BS	Ohio Medicaid	Modifier HH: Integrated Mental Health and Substance Abuse	Modifier HD: Pregnant/ Parenting Women	Modifier H9: Court Ordered
99203	**Physical Exam -30 min**	$114.50	$57.20	$91.26	$53.48			
99204	**Physical Exam -45 min**	$174.33	$68.90	$91.26	$81.55			
99205	**Physical Exam -60 min**	$216.35	$82.70		$102.47			
H0001	**Alcohol and Drug, Assessment**				$96.24			
H0003	**Alcohol and Drug, Screening**				$60.00			
H0004	**BH Counseling per 15 minutes**		$19.95		$22.50		$28.56	
H0005	**Alcohol and Drug Counseling; Group per 15min**		$4.71		$9.52		$9.54	
H0006	**Alcohol and Drug Counseling; Case Management**				$78.17			
H0010	**Alcohol and Drug Counseling; Sub acute Detoxification Inpatient**							

Continued

HCPCS/ CPT Code	Service Name	Medicare	Medi-Cal	BC/BS	Ohio Medicaid	Modifier HH: Integrated Mental Health and Substance Abuse	Modifier HD: Pregnant/ Parenting Women	Modifier H9: Court Ordered
H0012	**Alcohol and Drug Counseling; Sub acute Detoxification Outpatient**							
H0015	**Alcohol and Drug Services, Intensive Outpatient**		$61.05		$136.90		$73.04	
H0016	**Alcohol and Drug Services, medical/somatic**				$176.28			
H0017	**Behavioral Health Residential**						$89.90	
H0018	**BH Short term residential**							
H0019	**BH long term residential**							
H0020, HG	**Alcohol and Drug, Methadone**		$11.34		$80/wk		$12.21	
H0022	**Alcohol and Drug, Intervention**							
H0048	**Alcohol and Drug testing**							
H0049	**Alcohol and Drug Screening**							
H0050	**Alcohol and Drug, brief intervention**							
J2315	**Injection, Naltrexone**				$1.88			

Continued

HCPCS/ CPT Code	Service Name	Medicare	Medi-Cal	BC/BS	Ohio Medicaid	Modifier HH: Integrated Mental Health and Substance Abuse	Modifier HD: Pregnant/ Parenting Women	Modifier H9: Court Ordered
S0280	**Medical Home Program, initial plan**							
S0281	**Medical Home program, maintenance of plan**							
S5190	**Wellness assessment**		$100.00					
S9075	**Smoking Cessation**							
S9976	**Lodging, Per Diem**							
T1007	**Alcohol and Drug, treatment plan development/modification**							
T1012	**Alcohol and Drug, Skills development**							

6: COLLECTING CLIENT FEES/SLIDING FEE SCALE

Sliding fee schedules are locally derived mechanisms (discounts) to address how to equitably charge patients for services rendered. The mechanism must be set forth in writing describing the formal policy, the fees/discounts, and eligibility. The fees are set based on federal poverty guidelines, and patient eligibility is determined by annual income and family size. Schedules are established and implemented to ensure that a non-discriminatory, uniform, and reasonable charge is consistently and evenly applied on a routine basis to all patients. For patients whose income and family size place them below the poverty line, a "typical" nominal fee is usually charged. Patients between 101% to 200% of the federal poverty level are expected to pay some percentage of the full fee. A sliding fee schedule applies only to amounts charged to patients. Billing for third party coverage, that is, Medicare and Medicaid, private insurance carriers etc., is set at the usual customary charge.[41]

Developing a Sliding Fee Schedule

Each provider should take the following into consideration when developing a sliding fee schedule:

- Policy must be in writing and non-discriminatory;
- No patient is denied services due to inability to pay;
- Signage is posted to ensure that patients are aware of availability of discounted/sliding fee;
- Patients complete a written application to determine financial eligibility for the discounted/sliding fee;
- The patient's privacy is protected;
- Records are kept to account for each visit or treatment and corresponding charges (if any);
- Providers may establish any number of incremental percentages (discount pay class) as they find appropriate between 100 to 200% of the federal poverty level;
- Patients above 200% of the federal poverty level may be charged the full fee for the service(s) or, providers may continue to charge incremental percentages of the full fee for services when the patient income is above 200% of poverty, until 100% of the fee is reached. [42]

Health Center Requirements

In addition to establishing and following a written sliding fee schedule policy, health care providers must follow certain other provisions. The fee schedule must be consistent with locally prevailing rates, and must be designed to cover the reasonable costs of operation. Health care providers should also make all

[41] National Health Service Corps. "Discounted/Sliding Fee Scale Information Package." March 2008. Accessed 16 May 2011. <http://nhsc.hrsa.gov/communities/discountedfee.pdf>

[42] Arizona Department of Health Services. "Discounted/Sliding Fee Scale Information Package." 2005. Accessed 16 May 2011. <http://www.azdhs.gov/hsd/slidingfeeinformationpackage2005.pdf>

reasonable effort to obtain reimbursement from third-party vendors—either public (Medicare, Medicaid, CHIP, etc) or private health insurance (for patients who are eligible for coverage). The third-party payers should be billed on the basis of the full fee amount and payments for such services without the application of any discount. Additionally, the health care provider's governing body must approve the sliding/discounted fee schedule. The board should also review and update the fee schedule on a regular basis.[43]

Eligibility and Application

Verification of eligibility for discounted fees for the service provider can come in several different forms. Typically, tax returns and pay stubs are needed to verify income, but eligibility may also be based on the patient's current participation in certain other federal/state public assistance programs such as:

- Social Security Income (Disability);
- Temporary Assistance for Needy Families (TANF);
- Free or reduced public school lunch;
- Other federal/state public assistance programs may apply

The sliding fee schedule must be applied to all patients that are eligible based on the providers criteria outlined in their fee schedule policy documentation. It must be consistently applied to all recipients of treatment in the entirety of the site/location, without regard to the particular practitioner who treats them.[44]

Sliding Fee Schedule Recommendations

Substance abuse treatment centers should implement a sliding/discounted fee schedule based on the federal poverty level guidelines. The table below shows federal poverty levels for individuals and families of various sizes. It also gives example percentages of the full payments to be paid by the patient. Patients that fall below 100% of the poverty line are not usually charged a percentage of the full charge. Instead, a typical nominal fee, often between $7 and $15 may be charged.[45] Health care providers should use this chart when developing their sliding fee schedule.

The table below is an example of a sliding/discounted fee schedule.

[43] www.bphc.hrsa.gov. Accessed 16 May 2010. <http://www.bphc.hrsa.gov/technicalassistance/taresources/slidingrequirements.html>

[44] National Health Service Corps. "Discounted/Sliding Fee Scale Information Package." March 2008. Accessed 16 May 2011. <http://nhsc.hrsa.gov/communities/discountedfee.pdf>

[45] National Health Service Corps. "Discounted/Sliding Fee Scale Information Package." March 2008. Accessed 16 May 2011. <http://nhsc.hrsa.gov/communities/discountedfee.pdf>

48 Contiguous States and the District of Columbia
Annual Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty

*Family Unit Size**	*Nominal Fee*	*10% Pay*	*25% Pay*	*40% Pay*	*55% Pay*	*70% Pay*	*85% Pay*	*100% Pay*
Poverty	**<100%**	**133%**	**175%**	**200%**	**250%**	**300%**	**350%**	**400%**
1	$10,890	$14,484	$19,058	$21,780	$27,225	$32,670	$38,115	$43,560
2	$14,710	$19,564	$25,743	$29,420	$36,775	$44,130	$51,485	$58,840
3	$18,530	$24,645	$32,428	$37,060	$46,325	$55,590	$64,855	$74,120
4	$22,350	$29,726	$39,113	$44,700	$55,875	$67,050	$78,225	$89,400
5	$26,170	$34,806	$45,798	$52,340	$65,425	$78,510	$91,595	$104,680
6	$29,990	$39,887	$52,483	$59,980	$74,975	$89,970	$104,965	$119,960
7	$33,810	$44,967	$59,168	$67,620	$84,525	$101,430	$118,335	$135,240
8	$37,630	$50,048	$65,853	$75,260	$94,075	$112,890	$131,705	$150,520

Note: For each additional person beyond 8, add $3,820.

For example, if a provider charged $100 a day for Residential R&B and the consumer was below 250% of poverty, then the charge should be $55 ($100/day * 55% = $55/day). The same example can be applied to all services provided across the SAPC provider network.

SECTION IX—BARRIERS, DISINCENTIVES, AND RECOMMENDATIONS

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1: BARRIERS AND DISINCENTIVES

With any Rate Study there are going to be some barriers and disincentives that will arise. The MGT team has identified the following barriers and disincentives related to the Rate Study.

Medi-Cal Reimbursement

SAPC's ability to reimburse on the Medi-Cal rates is limited. Medi-Cal sets rates for only eight of the 28 services defined in Section VI: Standards of Care. Those services are found below.

HCPCS Code	Service Name	Medi-Cal
99203	**Physical Exam -30 min**	$57.20
99204	**Physical Exam -45 min**	$68.90
99205	**Physical Exam -60 min**	$82.70
H0004	**BH Counseling per 15 minutes**	$19.95
H0005	**Alcohol and Drug Counseling; Group per 15min**	$4.71
H0015	**Alcohol and Drug Services, Intensive Outpatient**	$61.05
H0020, HG	**Alcohol and Drug, Methadone**	$11.34
S5190	**Wellness Assessment**	$100.00

Changing Staff Requirements

Changing staffing requirements will impact rate setting in that in general, the higher the level of credentialing required, the higher the cost of providing the services. The salary expense is a function of program definitions, staffing models, and licensure levels, and it is important for SAPC to discretely define the levels required when paying providers for a service.

Residential Bed Vacancy

Low occupancy rates can limit a provider's ability to recover the cost of the program if the staffing is not closely monitored and adjusted. For example, if a Residential provider experiences a 50% occupancy rate for an extended period of time and does not reduce staff levels, then the cost per day will be high versus the rate. SAPC can choose to implement a minimum occupancy rate that would ensure that all future rates are based on a minimum level of days.

Local, State, and Federal Reporting Requirements

SAPC should not experience any barriers or incentives related to local, state, or federal reporting. In fact, SAPC should look to implement more reporting requirements around cost and utilization data so that rates can be based on actual provider costs and utilization in future periods.

Availability of Trained Staff and Limitations of Current Provider Contracts

If staffing levels are not discretely defined and mandated by service type, SAPC will have a hard time developing a standardized fee schedule. Workforce shortages may drive providers to hire lower staffing levels (such as a registered versus licensed substance abuse counselor). This can impact cost and quality of service across the SAPC provider network.

2: RECOMMENDATIONS

Based on the data gathering and analysis conducted in the Rate Study, and mindful of SAPC's ultimate goals for this program, the MGT team has compiled a number of short- and long-term recommendations for SAPC's consideration. The implementation of these recommendations will result in a streamlined, HCPCS-based, billing and reporting system that effectively captures significant cost variables, reflecting the true cost of providing substance abuse treatment in Los Angeles County.

#	*Description*	*Short Term Recommendations*	*Long Term Recommendations*
1	Institute FFS rates for adult populations	☑	
	Provide outreach and education to providers related to the new FFS rates	☑	
	Develop a training program that supports providers through transition for providers	☑	
2	Implement a SAPC Management Information System	☑	
	Develop ability to adjudicate FFS claims on a weekly or monthly basis	☑	
	Develop a review process to monitor utilization trends	☑	
	Identify risk areas and implement prior authorization programs for services that exceed budgeted units.	☑	
3	Implement a Cost Reporting system that supports the FFS environment	☑	
	Require cost by service code	☑	
	Streamline provider position titles	☑	
	Streamline Modality Names	☑	

Continued

#	*Description*	*Short Term Recommendations*	*Long Term Recommendations*
	Specify Full Time Equivalent (FTE) for each service	☑	
	Provide greater definition around the reporting of administrative costs on the cost report	☑	
	Document service-related costs at the level of HCPCS definitions	☑	
	Document services provided to special populations	☑	
4	Develop an appeals process for costs that exceed the established rate by service code	☑	
5	Long Term Recommendations		
	Annually collect cost and utilization data for rate setting		☑
	Annually establish rates for services based on cost report data		☑
	Annually provide support for providers FFS billing operations and rate establishment		☑
	Annually audit to ensure program compliance		☑
	Implement a Pay for Performance program		☑

1. Institute FFS Rates for Adult Populations

SAPC should implement the FFS rates identified in the Rate Study for adult populations. Providers in the SAPC network will need to be informed immediately so they can begin to prepare for the administrative changes that will impact budgeting, cash flow, and overall program operations with the implementation of these rates. In conjunction with the implantation of these rates, SAPC should develop a training program to assist the providers through this transition. Providers will have a host of changes to administrative activities, such as billing and cost reporting, that will be impacted by the change, and they will need time to transition to the new FFS system.

2. Implement a SAPC Management Information System

Providers will now be responsible for submitting claims to SAPC on a FFS basis. To be able to accommodate those billings, SAPC will need to develop the internal protocols and systems to do so, including developing a modified CMS-1500 claim form from providers. The SAPC system should have the ability to accept and pay providers based on the claim form, and the system needs to be able to monitor utilization to identify trends and risk areas, given the fixed budget that SAPC has for provider services. Prior authorization programs may need to be implemented should providers over or under bill.

In addition, providers may need to invest in their information systems for utilization tracking, reporting, and bill submission. Moving to a FFS model is not an insignificant event for the providers, and it may be costly.

3. Implement a Cost Reporting System that Supports the FFS Environment

Streamline Provider Position Titles

Position titles play a crucial role in the determination of rates as higher levels of credentialing tend to warrant higher personnel expenditures, and thus, a higher reimbursement for services rendered. For example, for reasons related to the complexity of the client's condition, there is value added when a licensed psychologist provides an individual counseling session rather than a registered counselor. The rates for these services can reflect that value and incentivize the use of more highly qualified staff. Determining an appropriate rate increase based on staff credentials requires a streamlined process for classifying staff.

Currently, there are 834 unique position titles within the cost report database. The addition of position titles on a free-form basis reduces their value in the report as it diminishes the ability to compare staff ratios across providers. The MGT team recommends instituting a drop-down list of pre-determined position titles with each title providing enough detail on the staff member's qualifications to warrant an accurate rate reflection.

Specify Full Time Equivalent (FTE) for Each Service

An accurate FTE count can be used to analyze both provider productivity and the efficiency of services rendered. As part of the cost report revision process, the MGT team requested that agencies provide an FTE count for each salary entered on the cost report. Several providers called the cost report helpline with questions on this requirement, and the analysis suggests that a subset of providers entered FTE counts inaccurately. The MGT team recommends that SAPC require the inclusion of FTEs as part of regular reporting practices and provide training where needed on how to accurately calculate this number.

Provide Greater Definition Around the Reporting of Administrative Costs

It would be acceptable for providers to report administrative costs as directly allocated through cost report schedule P1a, which includes costs for program staff, or indirectly through the use of cost report schedule P5, which explicitly requires administrative cost information. However, SAPC needs to be able to discretely identify all administrative costs being charged to contracts so that appropriate comparisons and cost limitations can be established. If SAPC wishes to implement a uniform cost reporting system, they must develop better definitions and instructions about the reporting of costs and cost allocation.

Document Service-Related Costs at the Level of HCPCS Definitions

With the goal of instituting a reporting system based on HCPCS coding, the MGT team recommends that SAPC providers begin tracking units and costs internally at a level consistent with the recommended HCPCS coding structure as soon as possible. Significant changes to the current method of tracking units and costs will include the breakout of room and board from all other residential costs, and separate tracking for case management, screening, assessment, and drug testing related costs. Completing this

shift in operations will require varying lengths of time depending on provider resources and current tracking methods. However, once complete, these costs will provide a very strong basis for the determination of rates in future years.

Document Services Provided to Special Populations

As described previously in the Rate Study, treating special populations, including individuals who are HIV positive, indigent, court-referred, mothers, or pregnant, results in a per-unit cost increase. To capture these additional costs, providers will need to document the treatment of these individuals and classify costs accordingly.

4. Develop an Appeals Process for Costs that Exceed the Established Rate by Service Code

SAPC will experience some providers that are adversely affected by the rate changes. This could occur for a number of reasons including historic rates were set too high; the provider lacks a true Information System to track cost and utilization; the provider cannot adapt quickly enough to manage new cash-flow demands; etc. It is not the goal of SAPC to put these providers out of business, so SAPC will need to develop a process to manage these "hardship" providers that is fair and equitable to the entire provider network.

5. Long-Term Recommendations

The MGT team has discussed numerous methodologies which (because of complexity and scope) will require a long-term strategy to implement. These themes are pervasive throughout this Rate Study and should be considered as a part of a comprehensive plan. These ideas include annually collecting cost and utilization data, establishing rates, and providing support for providers' FFS billing operations and rate establishment. SAPC will be moving to a new FFS payment system that will require tighter fiscal and administrative controls not only for SAPC, but for the provider community as well. The reimbursement process will become a true revenue cycle and will need to be proactively managed for efficiency and economy.

SAPC should also consider developing a quality-based payment method in future years. Quality-based payment methodologies, otherwise known as "Pay for Performance (P4P)" have achieved increasing interests and support from providers and insurers in the U.S. health care system in recent years. SAPC should review national policies on quality-based payment for substance abuse treatment programs and move to identify and build an action plan to build P4P measures into the system. CMS has recently implemented quality payment standards for hospitals that measure compliance and outcomes of heart attack, heart failure, infection control, pneumonia, and patient satisfaction. These measures will be utilized to create a P4P payment system for hospital payments for Medicare recipients. Similar payment programs are being developed by public/private payors for institutional and non-institutional service settings across the country. SAPC could work to develop a similar program for the network of substance abuse providers in Los Angeles County.

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SECTION X: APPENDICES

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APPENDIX A: ADDITIONAL RESPONSES TO INTERVIEW QUESTIONS

King County, Washington

Rate Determination	Provider Rate Verification	Rate Adjustment Factors	Determining Year-To-Year Rate Changes	Tracking Systems
The County pays providers at one of two rate levels, depending on the funding source. For state funded programs, providers are paid according to the Washington State rate, or "Title 19 Rates". Washington State determined these rates based on a consultant rate study in the late 1980s, and has increased rates since then on an irregular basis. For County funded programs, the County pays a higher rate. The County rate is approximately 20 percent higher than the Washington State rate.	Because the County only allows for two rate levels, it uses a Specified Service Cost RFP model, and derives its rates from the Washington State rates – King County does not formally determine rates.	Given King County's high cost of living and business relative to the rest of the State, the County pays more than the statewide cost rates. The County does this to retain capable providers and to retain qualified and experienced provider staff. The County based the 20 percent rate increase on its own cost analysis, and through discussion with its providers. The County pays all providers a flat rate, and does not adjust its rates due to provider location or staffing costs.	The County bases its year-to-year rate increases based on changes to the Washington Title 19 rates. The State intended to increase costs between 1 and 1.5 percent per year, but that has not occurred in the past few years. Therefore, the County has not increased rates in its own programs.	The County uses the State's 'Target', online tracking system to track and review provider activity. The County pays providers based on reports that they generate from the 'Target' system.

Orange County, California

Rate Determination	Provider Rate Verification	Rate Adjustment Factors	Determining Year-To-Year Rate Changes	Tracking Systems
The County determines rates using a combination of market competition, historical precedence, and benchmarking. To determine rates for a particular program, (unless rates are already specified by the state or federal governments), the County uses an Open Cost RFP model The County reviews provider submissions against a number of quality and cost criteria, and enters into final negotiations with one or more providers.	The County does not have a threshold amount by modality, or percentage that it uses to review rates. Staff use their best judgment to determine if they should review provider rates. If the County chooses to verify rates, they either: • Have County staff review the rates based on historical precedence, and staff experience. • Verify rates submitted in the provider's proposal against benchmarks, such as provider walk-in rates, and against Drug Medi-Cal rates.	The County pays some providers higher rates if they use rented facilities, and adjusts rates broadly in line with rental costs. The County has no formal mechanism to determine rate increases. County staff make rate increases based on requests from providers or after reviewing providers' actual costs.	The County does not have a formal mechanism to increase provider rates each year. The County normally awards providers multi-year contracts, and each year providers have the opportunity to request rate increases based on increased resource costs. The County also reviews providers' summarized actual expenditures, which may demonstrate the need for increased rates.	The County uses the 'IRIS' database to track client metrics. County staff develop key metrics from IRIS and use the data for state reporting purposes. Providers can directly enter data into IRIS.

San Diego County, California

Rate Determination	Provider Rate Verification	Rate Adjustment Factors	Determining Year-To-Year Rate Changes	Tracking Systems
The County primarily uses a market competition process to select vendors, but uses a Specified Service Cost RFP approach. In other instances, the County uses an Open Cost RFP model. The County reviews provider rates, and selects the rate, which provides the best service and value to the County. For those Open Cost RFPs where all provider rates are above the Medi-Cal cost ceiling, the County sets service rates by modality by determining the average cost for all providers, and using that rate as the basis for contract negotiation.	The County verifies costs primarily by reviewing cost data from previous years from all providers. The County believes that the Drug Medi-Cal rate in many instances does not cover provider costs, and may set rates above the Drug Medi-Cal cost ceiling. The County does not have a system to set rates above the Drug Medi-Cal cost ceiling, but relies on staff experience and market knowledge to set an appropriate rate.	The County does make slightly different payments to different providers throughout the County. This is due to the varying costs associated with facilities and, to a minor extent, staffing costs. Facilities costs for residential programs vary across the County, due to the local costs of residential facilities. Provider staffing costs vary based on cost of living differentials in some parts of the County.	The County does not have a formal mechanism to increase costs each year. County staff use their professional judgment and relationship with providers to determine if a cost increase is warranted. The County also has access to full account ledgers from providers, and reviews actual costs each year. Cost increases are uncommon. In the last five years there have been no increases in provider costs for any modality.	The County imports data into the State's proprietary software system from its own tracking web-based system called 'SanDWITF'. Providers enter data into 'SanDWITF' and present accounts for processing every quarter or month.

Riverside County, California

Rate Determination	Provider Rate Verification	Rate Adjustment Factors	Determining Year-To-Year Rate Changes	Tracking Systems
The County releases a Specified Service Cost RFP by providing a rate range for each modality. Providers submit their rates for each modality as part of a proposal. The County reviews provider rates and program approach and awards contracts based on provider experience, service quality, and provider location.	Prior to the County releasing an RFP, the County will review the accounts for all or selected providers to determine their actual costs. The County uses this to establish upper and lower acceptable costs that it publishes in the RFP.	The County allows for significant cost differences between providers, based on the relative differences in facilities costs and the relatively higher costs that smaller providers incur in smaller or isolated communities.	The County has not changed rates in recent years and expects that providers' rates will be the same during the next three to five years in each contract cycle.	The County uses a web-based centralized client and service tracking system that vendors and County clinics access to manage clients.

APPENDIX B. PERCENT OF TOTAL COSTS FOR EACH COST CATEGORY

The following table presents the data collected from the "as submitted" and "revised" cost reports for contract expenses. Agencies have the option to decide how to report administrative costs, thus the 0% shows that there was no data for that particular cost category in that SPA.

Table B.1. Cost Categories as Percentage of Total Expenses, by SPA (All Modalities)

Description	1	2	3	4	5	6	7	8	Total
Salary	34.60%	40.97%	41.23%	45.42%	36.61%	41.64%	43.14%	41.92%	41.77%
Benefit	6.68%	8.95%	11.06%	11.40%	12.87%	10.03%	12.03%	13.64%	11.10%
Facility Rent Lease of Depreciation	7.30%	9.26%	5.68%	7.57%	5.45%	6.62%	6.74%	7.65%	7.10%
Equipment and Other Assets	0.17%	0.25%	1.00%	0.40%	0.66%	1.05%	0.81%	1.11%	0.78%
Other Direct Costs	13.19%	18.19%	20.40%	21.19%	26.57%	17.97%	20.25%	21.56%	19.82%
Equipment Depreciation	11.46%	7.52%	4.55%	3.61%	2.98%	5.35%	3.13%	2.96%	4.75%
Administrative Overhead	0.65%	5.26%	9.53%	8.71%	14.87%	8.71%	10.08%	8.80%	8.38%
Administrative Overhead	0.00%	1.12%	2.31%	0.51%	0.00%	7.57%	0.74%	1.72%	2.34%
Administrative Overhead	25.95%	8.50%	4.24%	1.17%	0.00%	1.07%	3.08%	0.65%	3.95%
	100.00%	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Table B.2 depicts the cost structure for Residential Services as percentages of total costs. This table shows the increase in "Other Direct Costs" associated with Residential services as compared to Table A.1 above for Total Services.

Table B.2. Cost Categories as Percentage of Total Expenses—Residential Services Only, by SPA

Description	1	2	3	4	5	6	7	8	Total
Salary	44.17%	45.80%	39.51%	43.90%	32.51%	39.71%	46.18%	36.40%	41.42%
Benefit	8.62%	10.47%	10.83%	10.51%	10.84%	10.64%	10.70%	11.65%	10.73%
Facility Rent Lease of Depreciation	3.59%	7.43%	2.78%	6.62%	4.28%	5.54%	4.06%	10.99%	5.99%
Equipment and Other Assets	0.28%	0.20%	1.12%	0.36%	0.73%	1.06%	0.72%	1.45%	0.82%
Other Direct Costs	16.88%	23.31%	27.88%	26.55%	35.19%	17.32%	23.31%	28.61%	24.78%
Equipment Depreciation	0.54%	2.15%	2.16%	2.66%	1.69%	1.64%	0.52%	1.31%	1.76%
Administrative Overhead	0.00%	7.42%	9.56%	7.13%	14.76%	6.85%	7.66%	7.31%	7.66%
Administrative Overhead	0.00%	1.39%	2.29%	0.46%	0.00%	15.62%	1.28%	1.00%	3.53%
Administrative Overhead	25.92%	1.83%	3.88%	1.81%	0.00%	1.62%	5.58%	1.29%	3.32%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	100.00%

Table B.3. Cost Categories as Percentage of Total Expenses—Counseling Services, by SPA

Description	1	2	3	4	5	6	7	8	Total
Salary	35.79%	50.48%	51.18%	52.28%	47.26%	46.83%	51.75%	45.52%	47.68%
Benefit	6.78%	9.11%	10.57%	13.59%	12.44%	10.77%	12.43%	14.99%	11.49%
Facility Rent Lease of Depreciation	11.96%	14.72%	11.25%	7.73%	7.90%	7.41%	6.47%	9.19%	9.12%
Equipment and Other Assets	0.04%	0.14%	1.13%	0.64%	0.00%	0.85%	1.33%	0.73%	0.72%
Other Direct Costs	16.49%	13.57%	14.71%	9.54%	17.17%	16.74%	17.90%	17.77%	15.25%
Equipment Depreciation	0.00%	2.13%	2.11%	0.91%	2.28%	7.77%	1.18%	1.42%	2.32%
Administrative Overhead	0.78%	2.30%	2.26%	15.14%	12.93%	4.64%	8.74%	6.40%	6.80%
Administrative Overhead	0.00%	3.89%	5.89%	0.16%	0.00%	2.40%	0.21%	3.98%	1.92%
Administrative Overhead	28.15%	3.66%	0.89%	0.00%	0.00%	2.58%	0.00%	0.00%	4.71%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

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APPENDIX C. SALARY AND PRODUCTIVITY ANALYSIS

As previously stated, providers had the opportunity to review and include additional information on the FY 2009-10 cost reports. The MGT Team collected additional FTE data from 19 providers and began analyzing for errors, omissions, or other issues. From this review a few items needed correction:

- Review of the as-filed cost report FTEs compared to the as-filed salaries for this group of providers identified an average annual salary of $3,055 (4,048.33 FTEs/$12,368,840 Salary). MGT considered this to be low and therefore conducted further analysis.
- Review the calculated salary by multiplying the FTEs (4,084.33) by the Monthly Salary (times 12) resulted in an average annual salary of $30,707 (4,048.33 FTES/$124,311,202 Salary). This average salary seemed appropriate but upon further review of the data we identified large variations that could not be accurate (Low Average Annual Salary of $195 and a High Average Annual Salary of $1,438,176).

MGT then reviewed and smoothed the data by either utilizing the as-filed cost report salaries or salaries derived by multiplying the monthly amount by 12 months. If a provider had accurate monthly and as-filed data the as-filed data was used. This occurred with ten (10) providers. Table C.1 on the following page defines the providers and the methods used to define total salary for each provider type:

Table C.1—Agencies included in FTE/Salary Analysis

Agencies included in FTE/Salary Analysis		
DESCRIPTION	MONTHLY SALARY CALCULATION	AS-FILED SALARY
Behavioral Health Services		☑
California Hispanic Commission On Alcohol And Drug Abuse	☑	
Chabad Of California	☑	
Didi Hirsch Psychiatric Service	☑	
Grandview Foundation		☑
Homeless Health Care Los Angeles	☑	
Joint Efforts		☑
Los Angeles Centers For Alcohol And Drug Abuse		☑
Mary Lind Recovery Centers		☑
Mid Valley Recovery Services	☑	
People Coordinated Services Of Southern California		☑
Phoenix Houses Of Los Angeles		☑
Prototypes		☑
South Bay Alcoholism Services		☑
Southern California Alcohol And Drug Programs		☑
Substance Abuse Foundation Of Long Beach		☑
Tarzana Treatment Center		☑
Verdugo Mental Health Center		☑
Volunteers Of America Of Los Angeles		☑

The last step of our analysis involved reviewing the accuracy of the actual FTE detail. Upon this review MGT noted that 2 providers (California Hispanic Commission on Alcohol and Drug Abuse Services and Mid-Valley Recovery Services) were outliers in their reported FTEs. For this reason, MGT removed the 2 providers from the analysis that follows. Therefore, the final list of providers reviewed for MGT's salary analysis covered seventeen (17) providers and nine (9) service modalities.

The MGT Team's analysis identified $17.1 million in salaries paid to 567 FTEs. Administrative, Case Managers, Program Managers, and Substance Abuse Counselors made up the majority of the salaries and FTEs. The overall administrative average annual salary was $35,042 and Direct Service average

annual salary was $28,741. The highest average salary was for Child Care at $55,395 and the lowest was Case Managers at $15,158.

Table C.2 below is an analysis of the total salaries by position and their respective FTE's, along with the calculated average salary per FTE. The subtotals in italics represent the different cost categories for position types, either administrative or direct service.

Table C.2 Salary Analysis

Salary Analysis			
POSITION	**AMOUNT**	**FTES**	**AVERAGE PER FTE**
Administrative	$4,215,406	121.62	$34,660
Admissions	$6,383	0.18	$35,461
Finance	$431,729	11.00	$39,248
Subtotal-Administrative	**$4,653,518**	**132.80**	**$35,042**
Case Manager	$1,107,573	73.07	$15,158
Child Care	$156,214	2.82	$55,395
Clinical	$237,694	5.42	$43,855
Direct Service Other	$436,753	15.35	$28,453
Lab Technician	$662	0.02	$33,100
LCSW	$7,253	0.19	$38,174
LSW	$131,946	3.59	$36,754
LVN	$372,682	10.82	$34,444
Marriage Family Therapist	$499,988	13.98	$35,765
MSW	$47,702	1.66	$28,736
PA	$5,209	0.15	$34,727
Program Manager	$4,255,141	107.47	$39,594
Psychologist	$17,694	0.76	$23,282
RN	$288,918	5.20	$55,561
SA Counselor	$4,921,306	193.96	$25,373
Subtotal-Direct Service	**$12,486,735**	**434.46**	**$28,741**
Grand Total	**$17,140,253**	**567.26**	**$30,216**

The services defined cover 9 modalities. The table below, table C.3, identifies the breakdown by SPA. Residential makes up over $9.4 million in salary, Community Assessment and Service Program is $2.4 million, Outpatient Drug Free Individual and Group Counseling is $2.5 million, and Day Rehabilitative is about $250,000.

Table C.3 Total Salaries by Service Modality, by SPA

Total Salaries by Service Modality, by SPA									
Service Modality	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Alcohol/Drug Free Housing		$15,458						$27,518	$42,976
Community Assessment and Service Program	$129,309		$523,331	$312,635	$759,865		$270,681	$418,119	$2,413,940
Day Care Rehabilitative (DCR)		$207,622	$44,870						$252,492
Outpatient Drug Court Treatment and Recovery Services	$20,736		$34,627					$40,420	$95,782
Outpatient Drug Free Group Counseling	$21,419		$6,807	$245,418		$124,130	$49,351	$346,711	$793,837
Outpatient Drug Free Individual Counseling	$367,598	$9,311	$27,963	$397,702	$261,126	$7,784	$47,891	$610,904	$1,730,279
Residential	$430,712	$2,407,571	$1,403,626	$1,517,330	$80,019	$278,284	$1,274,727	$2,026,795	$9,419,064
Residential Detoxification		$54,953	$205,589					$421,046	$681,588
Satellite Housing Center								$611,733	$611,733
Unidentified	$40,898	$46,685	$99,094	$175,558				$736,325	$1,098,560
Grand Total	**$1,010,672**	**$2,741,600**	**$2,345,907**	**$2,648,643**	**$1,101,010**	**$410,198**	**$1,642,650**	**$5,239,572**	**$17,140,253**

MGT also identified FTEs over the 9 modalities and 8 SPAs, as shown in table C.4. Residential providers make up the bulk of the FTEs with 312. The other large programs are Community Assessment and Service Program (110) and Outpatient Drug Free Counseling (64).

Table C.4: FTEs per Service Modality, by SPA

FTEs per Service Modality, by SPA									
Service Modality	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Alcohol/Drug Free Housing		0.23						0.93	1.16
Community Assessment and Service Program	11.68		54.89	7.50	18.00		6.99	11.44	110.50
Day Care Rehabilitative (DCR)		5.38	1.26						6.64
Outpatient Drug Court Treatment and Recovery Services	2.10		1.30					1.28	4.68
Outpatient Drug Free Group Counseling	0.91		0.21	5.58		4.02	1.55	7.87	20.14
Outpatient Drug Free Individual Counseling	9.64	0.16	0.90	10.95	5.51	0.33	1.12	16.13	44.74
Residential	16.43	73.81	48.01	54.91	3.36	10.02	43.88	61.85	312.27
Residential Detoxification		1.34	5.35					10.75	17.44
Satellite Housing Center								14.43	14.43
Unidentified	1.16	1.42	3.35	4.35				24.98	35.26
Grand Total	**41.92**	**82.34**	**115.27**	**83.29**	**26.87**	**14.37**	**53.54**	**149.66**	**567.26**

MGT analyzed staffing and salary data for the sample group specific to Residential and across the 8 SPAs. The chart below defines FTEs by Position, Salary by Position, Average Salary by Position, Hours per Day, and Salary per Day:

- FTEs by Position (Table C.5)—approximately 75% of the 312 FTEs reported in Residential Services are Direct Service staff. Most of the Direct Service positions are staffed by Substance Abuse Counselors and Program Managers.
- Salary by Position (Table C.6)—approximately 72% of the $9.4M in salaries is related to Direct Service. Substance Abuse Counselors and Program Managers made up over $5.3M of the Direct Service Salary.
- Average Salary by Position (Table C.7)—the average salary for administrative and direct staff are both around $28,000 per year. The highest paid staff category is Program Managers and the lowest paid is the Substance Abuse counselors.
- Hours per Day, Salary per Day (Table C.8)—the average hour per day for the sample was 3.87 for the entire sample. Approximately 1 hour was provided by administrative staff and 2.8 hours by direct staff. The highest SPA was 2 with 12.43 hours per day and the lowest was 5 with 2.22 hours per day. The average salary per day for the sample was $56.13 for the entire sample. Administrative staff accounted for $15.20 and Direct Service staff accounted for $40.93 of the per day salary. The highest SPA was 2 with a salary per day of $194.98 and the lowest was 5 with $25.45 per day.

Table C.5: Full Time Equivalents (FTEs)—Residential Services

Residential Services-FTEs									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Administrative	6.98	12.82	16.71	8.58	0.54	2.32	5	22.46	75.41
Admissions					0.18				0.18
Finance				0.24			0.96	2.38	3.58
Subtotal-Administrative	***6.98***	***12.82***	***16.71***	***8.82***	***0.72***	***2.32***	***5.96***	***24.84***	***79.17***
Case Manager	1.37	1.19	1.15	5.4		0.68	8.01	0.9	18.7
Child Care	0.47	1.05	0.52					0.05	2.09
Clinical			2.33				0.42		2.75
Direct Service Other	0.05	0.01	3.27	0.51	0.18	0.74	0.96	0.01	5.73
LCSW	0.14								0.14
LSW	0.33	0.03		3			0.08	0.03	3.47
LVN	2.13	0.24	0.11					2.26	4.74
Marriage Family Therapist				4.95	0.06			3	8.01
Program Manager	1.72	18.21	2.95	5.79	0.42	1.64	21.71	6.67	59.11
Psychologist				0.75					0.75
RN			0.3		0.18			0.04	0.52
SA Counselor	3.24	40.26	20.67	25.69	1.8	4.64	6.74	24.05	127.09
Subtotal-Direct Service	***9.45***	***60.99***	***31.3***	***46.09***	***2.64***	***7.7***	***37.92***	***37.01***	***233.1***
Grand Total	**16.43**	**73.81**	**48.01**	**54.91**	**3.36**	**10.02**	**43.88**	**61.85**	**312.27**

Table C.6 Total Salary—Residential Services

Residential Services-Total Salary									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**TOTAL**
Administrative	$142,007	$418,157	$510,857	$248,975	$8,770	$54,876	$152,524	$858,892	$2,395,057
Admissions					$6,383				$6,383
Finance				$13,209			$46,132	$89,674	$149,015
Subtotal-Administrative	***$142,007***	***$418,157***	***$510,857***	***$262,184***	***$15,153***	***$54,876***	***$198,656***	***$948,566***	***$2,550,455***
Case Manager	$36,446	$45,811	$33,183	$141,208		$20,777	$261,988	$32,827	$572,241
Child Care	$14,673	$39,705	$76,029					$872	$131,279
Clinical			$78,617				$13,977		$92,594
Direct Service Other	$5,019	$1,073	$83,543	$10,726	$4,383	$13,003	$20,176	$1	$137,924
LCSW	$4,321								$4,321
LSW	$21,616	$4,583		$89,856			$8,010	$2,448	$126,513
LVN	$61,989	$9,093	$3,993					$85,495	$160,570
Marriage Family Therapist				$199,680	$1,183			$84,288	$285,151
Program Manager	$63,931	$1,010,288	$113,322	$200,071	$19,739	$65,349	$551,206	$230,796	$2,254,701
Psychologist				$16,785					$16,785
RN			$10,708		$418			$2,106	$13,232
SA Counselor	$80,709	$878,861	$493,374	$596,820	$39,143	$124,279	$220,714	$639,398	$3,073,297
Subtotal-Direct Service	***$288,705***	***$1,989,414***	***$892,770***	***$1,255,146***	***$64,866***	***$223,408***	***$1,076,071***	***$1,078,229***	***$6,868,609***
Grand Total	**$430,712**	**$2,407,571**	**$1,403,626**	**$1,517,330**	**$80,019**	**$278,284**	**$1,274,727**	**$2,026,795**	**$9,419,064**

Table C.7: Average Salary—Residential Services

Residential Services—Average Salary									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**AVG**
Administrative	$20,345	$32,618	$30,572	$29,018	$16,241	$23,653	$30,505	$38,241	$27,649
Admissions					$35,461				$35,461
Finance				$55,038			$48,054	$37,678	$46,923
Subtotal-Administrative	***$20,345***	***$32,618***	***$30,572***	***$29,726***	***$21,046***	***$23,653***	***$33,332***	***$38,187***	***$28,685***
Case Manager	$26,603	$38,497	$28,855	$26,150		$30,554	$32,708	$36,474	$31,406
Child Care	$31,220	$37,815	$146,210					$17,430	$58,169
Clinical			$33,741				$33,279		$33,510
Direct Service Other	$100,387	$107,294	$25,548	$21,031	$24,350	$17,572	$21,017	$50	$39,656
LCSW	$30,864								$30,864
LSW	$65,503	$152,767		$29,952			$100,125	$81,600	$85,989
LVN	$29,103	$37,888	$36,302					$37,830	$35,280
Marriage Family Therapist				$40,339	$19,717			$28,096	$29,384
Program Manager	$37,169	$55,480	$38,414	$34,555	$46,998	$39,847	$25,389	$34,602	$39,057
Psychologist				$22,380					$22,380
RN			$35,693		$2,322			$52,656	$30,224
SA Counselor	$24,910	$21,830	$23,869	$23,232	$21,746	$26,784	$32,747	$26,586	$25,213
Subtotal-Direct Service	***$30,551***	***$32,619***	***$28,523***	***$27,233***	***$24,570***	***$29,014***	***$28,377***	***$29,133***	***$28,753***
Grand Total	**$26,215**	**$32,618**	**$29,236**	**$27,633**	**$23,815**	**$27,773**	**$29,050**	**$32,770**	**$28,639**

Table C8: Hours per Day, Salary per Day-Residential Services

Residential Services-Hours per Day, Salary per Day									
Description	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**TOTAL**
Total Days	6,559	12,348	30,443	48,899	3,144	9,055	17,895	39,456	167,799
Administrative Hours per Day	2.21	2.16	1.14	0.38	0.48	0.53	0.69	1.31	0.98
Direct Service Hours per Day	3.00	10.27	2.14	1.96	1.75	1.77	4.41	1.95	2.89
Total Hours per Day	**5.21**	**12.43**	**3.28**	**2.34**	**2.22**	**2.30**	**5.10**	**3.26**	**3.87**
Salary Per Day-Administrative	$21.65	$33.86	$16.78	$5.36	$4.82	$6.06	$11.10	$24.04	$15.20
Salary Per Day-Direct Service	$44.02	$161.11	$29.33	$25.67	$20.63	$24.67	$60.13	$27.33	$40.93
Salary Per Day-Total	**$65.67**	**$194.98**	**$46.11**	**$31.03**	**$25.45**	**$30.73**	**$71.23**	**$51.37**	**$56.13**

MGT analyzed staffing and salary data for the sample group specific to Counseling across the 8 SPAs. The chart below defines FTEs by Position, Salary by Position, and Average Salary by Position:

- FTEs by Position (Table C.9)—approximately 72% of the 65 FTEs reported as Counseling are Direct Service staff. Like Residential Services, Counseling Services are staffed mostly by Substance Abuse Counselors and Program Managers.
- Salary by Position (Table C.10)—approximately 72% of the $2.5M in salaries is related to Direct Service. Again, Substance Abuse Counselors and Program Managers make up most of the salary component.
- Average Salary by Position (Table C.11)—the average salary for administrative and direct staff is about $38,000 per year. This is significantly higher than the average of $28,000 for residential services. Counseling has higher paid clinical staff (RNs, Psychologist, and Clinical) that drives the higher salary. The highest average salary was SPA 2 with $58,000 per year. SPA 6 was the lowest paid SPA at slightly over $30,000 per year.

Table C.9 FULL TIME EQUIVALENTS (based on 2,080 hours)

Counseling Full Time Equivalents									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**TOTAL**
Administrative	2.15	0.01	0.11	2.81	1	1.1	0.23	8.14	15.55
Finance	0	0.03	0	0.1	0	0	0.12	2.38	2.63
Subtotal-Administrative	***2.15***	***0.04***	***0.11***	***2.91***	***1***	***1.1***	***0.35***	***10.52***	***18.18***
Case Manager	1.95	0	0	0.05	0	0.19	0.3	0.19	2.68
Clinical	0.44	0	0	0.19	0	0	0.19	0	0.82
Direct Service Other	0.59	0	0	0.55	0	0	0.31	0	1.45
LCSW	0.01	0	0	0	0	0	0	0	0.01
LSW	0.05	0	0	0	0	0	0	0	0.05
Marriage Family Therapist	0	0	0	0	0	0.57	0	1.6	2.17
Program Manager	1.58	0.12	0.1	6.2	2.06	0.21	0.37	2.07	12.71
Psychologist	0.01	0	0	0	0	0	0	0	0.01
RN	0.05	0	0	0	0	0	0	0	0.05
SA Counselor	3.72	0	0.9	6.63	2.45	2.28	1.15	9.62	26.75
Subtotal-Direct Service	***8.40***	***0.12***	***1.00***	***13.62***	***4.51***	***3.25***	***2.32***	***13.48***	***46.70***
Total	**10.55**	**0.16**	**1.11**	**16.53**	**5.51**	**4.35**	**2.67**	**24.00**	**64.88**

Table C.10 TOTAL SALARY

Counseling Services—Total Salary by Position Type									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**TOTAL**
Administrative	$58,552	$278	$3,159	$68,487	$34,176	$16,128	$7,899	$413,351	$602,030
Finance	$-	$1,911	$-	$4,455	$-	$-	$4,932	$89,674	$100,972
Subtotal-Administrative	***$58,552***	***$2,189***	***$3,159***	***$72,942***	***$34,176***	***$16,128***	***$12,831***	***$503,025***	***$703,002***
Case Manager	$75,281	$-	$-	$1,800	$-	$3,614	$9,452	$6,802	$96,949
Clinical	$29,986	$-	$-	$18,455	$-	$-	$19,798	$-	$68,239
Direct Service Other	$10,557	$-	$-	$17,407	$-	$-	$9,742	$-	$37,706
LCSW	$333	$-	$-	$-	$-	$-	$-	$-	$333
LSW	$1,914	$-	$-	$-	$-	$-	$-	$-	$1,914
Marriage Family Therapist	$-	$-	$-	$-	$-	$21,656	$-	$72,595	$94,251
Program Manager	$81,928	$7,122	$3,648	$360,326	$154,669	$15,884	$16,345	$96,831	$736,753
Psychologist	$909	$-	$-	$-	$-	$-	$-	$-	$909
RN	$3,552	$-	$-	$-	$-	$-	$-	$-	$3,552
SA Counselor	$126,005	$-	$27,963	$172,191	$72,281	$74,632	$29,074	$278,362	$780,508
Subtotal-Direct Service	***$330,465***	***$7,122***	***$31,611***	***$570,179***	***$226,950***	***$115,786***	***$84,411***	***$454,590***	***$1,821,114***
Total	**$389,017**	**$9,311**	**$34,770**	**$643,120**	**$261,126**	**$131,914**	**$97,242**	**$957,615**	**$2,524,116**

Table C.11 AVERAGE SALARY

Counseling Services—Average Salary by Position type									
Position	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Average**
Administrative	$27,233	$27,800	$28,718	$24,373	$34,176	$14,662	$34,343	$50,780	$30,261
Finance		$63,700		$44,550				$37,678	$48,643
Subtotal-Administrative	***$27,233***	***$54,725***	***$28,718***	***$25,066***	***$34,176***	***$14,662***	***$36,660***	***$47,816***	***$38,669***
Case Manager	$38,606			$36,000		$19,021	$31,507	$35,800	$32,187
Clinical	$68,150			$97,132			$104,200		$89,827
Direct Service Other	$17,893			$31,649			$31,426		$26,989
LCSW	$33,300								$33,300
LSW	$38,280								$38,280
Marriage Family Therapist						$37,993		$45,372	$41,682
Program Manager	$51,853	$59,350	$36,480	$58,117	$75,082	$75,638	$44,176	$46,778	$55,934
Psychologist	$90,900								$90,900
RN	$71,040								$71,040
SA Counselor	$33,872		$31,070	$25,971	$29,502	$32,733	$25,282	$28,936	$29,624
Subtotal-Direct Service	***$39,341***	***$59,350***	***$31,611***	***$41,863***	***$50,322***	***$35,626***	***$36,384***	***$33,723***	***$38,996***
Total	**$36,874**	**$58,194**	**$31,324**	**$38,906**	**$47,391**	**$30,325**	**$36,420**	**$39,901**	**$38,904**

MGT analyzed staffing and salary data for the sample group specific to Community Assessment and Service Program across the 8 SPAs. The chart below defines FTEs by Position, Salary by Position, and Average Salary by Position:

- FTEs by Position (Table C.12)—approximately 90% of the 111 FTEs reported as Community Assessment and Service Program are Direct Service staff. Case Managers make up the lion's share of the FTEs with over 49. However, reporting and coding of FTEs by positions seems skewed toward SPA 3 with 43.68 of the FTEs. This high percentage of Direct Service staff to Total is likely because of the low direct overhead associated with staffing a case management position for a provider.
- Salary by Position (Table C.13)—approximately 85% of the $2.4M in salaries is related to Direct Service. , Substance Abuse Counselors, Program Managers, and Case Managers make up most of the salary component.
- Average Salary by Position (Table C.14)—the average salary for administrative and direct staff is about $31,000 per year. This is in-line with the cost of Residential Services.
- Hours per Unit (Table C.15)—the average hours per unit are 4.18 hours for these providers. The high is SPA 5 with 11.09 and the low is SPA 3 with 9.41.
- Salary per Unit (Table C.16)—the average salary per unit is $43.87 with a high (SPA 5) of $225.01 and a low (SPA 1) of $18.07.

Table C.12: FTEs by Position Type (based on 2,080 hours) – CASC Services

CASC Services—Full Time Equivalents							
Position	**1**	**3**	**4**	**5**	**7**	**8**	**TOTAL**
Administrative		1.98	0.24	5		4.29	11.51
Subtotal-Administrative	***0***	***1.98***	***0.24***	***5***	***0***	***4.29***	***11.51***
Case Manager	2.3	43.68	1.36		2.2		49.54
Child Care			0.18		0.15		0.33
Clinical			0.42		0.7		1.12
Direct Service Other	0.46	5.34	0.04			0.52	6.36
MSW	0.58	0.89	0.19				1.66
Program Manager	2.33	3	1.47	9	1.02		16.82
SA Counselor	6.01		3.6	4	2.92	6.63	23.16
Subtotal-Direct Service	***11.68***	***52.91***	***7.26***	***13***	***6.99***	***7.15***	***98.99***
Total	**11.68**	**54.89**	**7.5**	**18**	**6.99**	**11.44**	**110.5**

Table C.13: Total Salary by Position – CASC Services

CASC—Total Salary							
Position	**1**	**3**	**4**	**5**	**7**	**8**	**TOTAL**
Administrative		$49,418	$10,385	$121,800		$168,366	$349,968
Subtotal-Administrative	**$-**	**$49,418**	**$10,385**	**$121,800**	**$-**	**$168,366**	**$349,968**
Case Manager	$75,721	$154,119	$48,871		$ 86,231		$364,942
Child Care			$2,851		$2,376		$5,227
Clinical			$18,729		$18,813		$37,541
Direct Service Other	$3,128	$174,924	$1,560			$26,680	$206,292
MSW	$12,954	$27,803	$6,945				$47,702
Program Manager	$20,100	$117,067	$77,503	$510,685	$54,415		$779,770
SA Counselor	$17,406		$145,791	$127,380	$108,847	$223,073	$622,497
Subtotal-Direct Service	**$29,309**	**$473,913**	**$302,250**	**$638,065**	**$270,681**	**$249,754**	**$2,063,972**
Grand Total	**$129,309**	**$523,331**	**$312,635**	**$759,865**	**$270,681**	**$418,119**	**$2,413,940**

Table C. 14: Average Salary per FTE, by Position Type – CASC Services

CASC Services -Average Salary							
Position	**1**	**3**	**4**	**5**	**7**	**8**	**AVG**
Administrative		$24,959	$43,269	$24,360		$39,246	$32,958
Subtotal-Administrative		***$24,959***	***$43,269***	***$24,360***		***$39,246***	***$32,958***
Case Manager	$32,922	$3,528	$35,935		$39,196		$27,895
Child Care			$15,840		$15,840		$15,840
Clinical			$44,592		$26,875		$35,734
Direct Service Other	$6,800	$32,757	$39,000			$51,308	$32,466
MSW	$22,334	$31,239	$36,552				$30,042
Program Manager	$8,627	$39,022	$52,723	$56,743	$53,348		$42,093
SA Counselor	$2,896		$40,498	$31,845	$37,276	$33,646	$29,232
Subtotal-Direct Service	***$11,071***	***$8,957***	***$41,632***	***$49,082***	***$38,724***	***$34,931***	***$30,733***
Grand Total	**$14,716**	**$26,077**	**$39,075**	**$34,327**	**$34,507**	**$40,862**	**$31,024**

Table C.15: Hours Worked per Unit of Service – CASC Services

CASC Services - Hours per Unit of Service							
Description	**1**	**3**	**4**	**5**	**7**	**8**	**Total**
Units of CASC Services	7,157	12,130	10,953	3,377	6,163	15,241	55,021
Administrative Hours per Unit	-	0.34	0.05	3.08	-	0.59	0.44
Direct Service Hours per Unit	3.39	9.07	1.38	8.01	2.36	0.98	3.74
Total Hours Per Unit	**3.39**	**9.41**	**1.42**	**11.09**	**2.36**	**1.56**	**4.18**

Table C.16: Salary Expense per Unit of Service – CASC Services

CASC Services- Hours per Unit, Salary per Unit							
Description	**1**	**3**	**4**	**5**	**7**	**8**	**Total**
Units of CASC Services	7,157	12,130	10,953	3,377	6,163	15,241	55,021
Salary Per Unit-Administrative	$-	$4.07	$0.95	$36.07	$-	$11.05	$6.36
Salary Per Unit-Direct Service	$18.07	$39.07	$27.60	$188.94	$43.92	$16.39	$37.51
Salary Per Unit-Total	**$18.07**	**$43.14**	**$28.54**	**$225.01**	**$43.92**	**$27.43**	**$43.87**

Day Rehabilitative providers only provided 6.64 FTEs and $250K of salary expense. The average salary was $40,000 for Direct Service FTEs and $29,000 for Administrative FTEs. The Hours per Unit were an average of 1.25 hours per unit and Salary per Unit of $22.85 units.

Table C. 17 FULL TIME EQUIVALENTS (based on 2,080 hours)

Day Rehabilitative—Full Time Equivalents			
Position	**2**	**3**	**Total**
Administrative	1.12	0.29	1.41
Subtotal-Administrative	***1.12***	***0.29***	***1.41***
Case Manager	0.99		0.99
Clinical	0.24		0.24
Direct Service Other	0.3		0.3
LCSW	0.02		0.02
LSW	0.03		0.03
Program Manager	0.76	0.38	1.14
RN	0.03		0.03
SA Counselor	1.89	0.59	2.48
Subtotal-Direct Service	***4.26***	***0.97***	***5.23***
Grand Total	**5.38**	**1.26**	**6.64**

Table C. 18 TOTAL SALARY

Day Rehabilitative—Total Salary			
Position	**2**	**3**	**TOTAL**
Administrative	$32,412	$8,188	$40,600
Subtotal-Administrative	***$32,412***	***$8,188***	***$40,600***
Case Manager	$35,101		$35,101
Clinical	$18,740		$18,740
Direct Service Other	$6,228		$6,228
LCSW	$867		$867
LSW	$1,335		$1,335
Program Manager	$47,780	$22,425	$70,205
RN	$2,479		$2,479
SA Counselor	$62,680	$14,257	$76,937
Subtotal-Direct Service	***$175,210***	***$36,682***	***$211,892***
Grand Total	**$207,622**	**$44,870**	**$252,492**

Table C. 19 AVERAGE SALARY

Day Rehabilitative—Average Salary			
Position	**2**	**3**	**Average**
Administrative	$28,939	$28,234	$28,794
Subtotal-Administrative	***$28,939***	***$28,234***	***$28,794***
Case Manager	$35,456		$35,456
Clinical	$78,083		$78,083
Direct Service Other	$20,760		$20,760
LCSW	$3,350		$43,350
LSW	$44,500		$44,500
Program Manager	$62,868	$59,013	$61,583
RN	$82,633		$82,633
SA Counselor	$33,164	$24,164	$31,023
Subtotal-Direct Service	***$41,129***	***$37,816***	***$40,515***
Grand Total	**$38,591**	**$35,611**	**$38,026**

Table C. 20 HOURS PER UNIT, SALARY PER UNIT

Day Rehabilitative—Hours per Unit, Salary per Unit			
Description	**2**	**3**	**Average**
Units of Day Rehabilitative	9,333	1,718	11,051
Administrative Hours per Unit	0.25	0.35	0.27
Direct Service Hours per Unit	0.95	1.17	0.98
Total Hours Per Unit	**1.20**	**1.53**	**1.25**
Salary Per Unit-Administrative	$3.47	$4.77	$3.67
Salary Per Unit-Direct Service	$18.77	$21.35	$19.17
Salary Per Unit-Total	**$22.25**	**$26.12**	**$22.85**

APPENDIX D. SAMPLE DISCOUNTED/SLIDING FEE APPLICATION

"SAMPLE" HEALTH CENTER
Family Assistance Plan Application

Name of Head of Household		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection.		

I certify that the information shown above is correct and understand verification is required for approval.

Name (Print) _____ Signature/Date _____

Office Use Only

Pay class approved: _____ Effective date: _____

Approved by: _____ Expiration date: _____