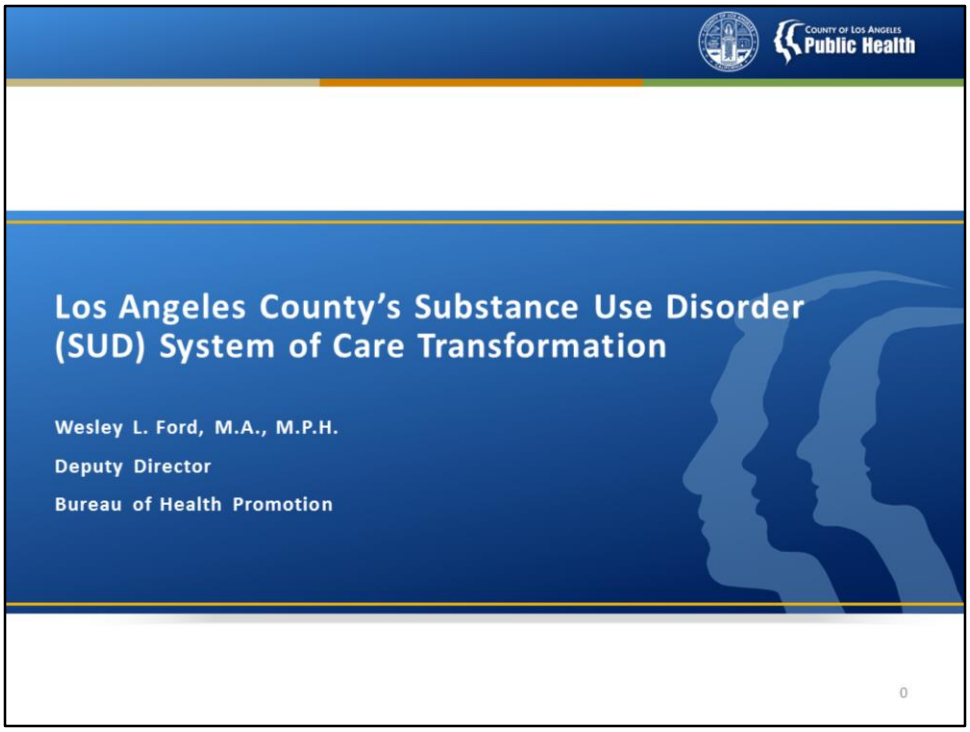
County of Los Angeles
Public Health
Los Angeles County's Substance Use Disorder (SUD) System of Care Transformation
Wesley L. Ford, M.A., M.P.H.
Deputy Director
Bureau of Health Promotion
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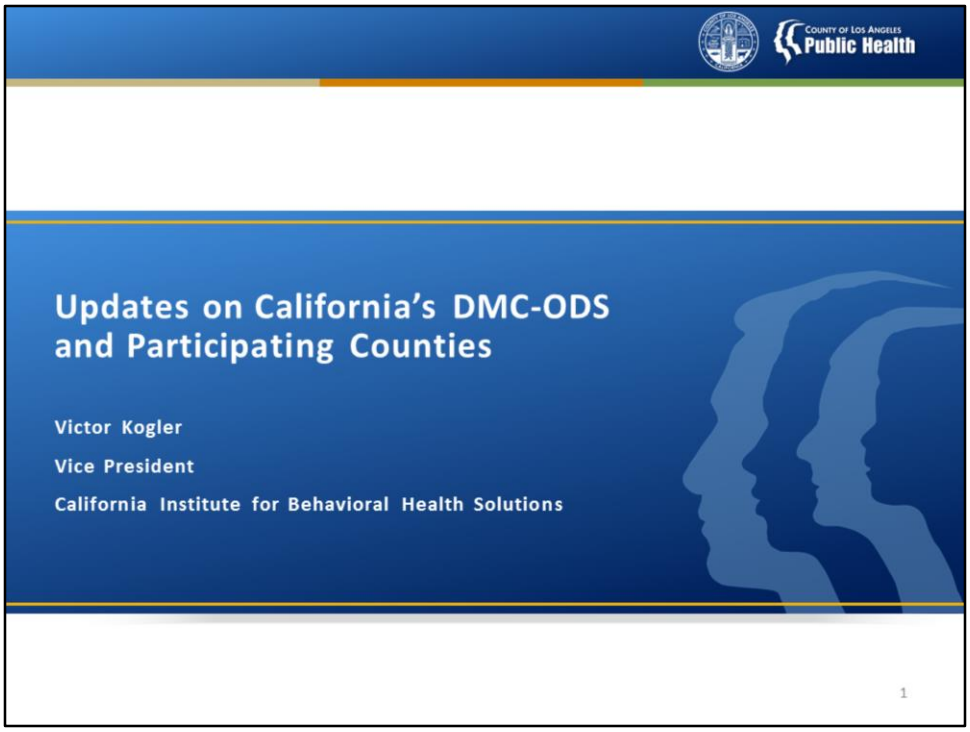
County of Los Angeles
Public Health
Updates on California's DMC-ODS and Participating Counties
Victor Kogler
Vice President
California Institute for Behavioral Health Solutions
1

## Waiver 101

- The approval of the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS) by the federal Centers for Medicare and Medicaid Services (CMS) paves the way for statewide transformation of the administrative, business and clinical aspects of safety net SUD treatment.

- Counties will be able to set provider reimbursement rates and expand access to SUD treatment services for adolescents and adults who are Medi-Cal eligible.

## Waiver 101

- Medicaid waivers provide for exemptions to federal regulation that permit states to implement managed care (under section 1915(b)) or demonstration projects (under section 1115).
- Demonstration waivers permit states to test and evaluate new approaches to systems operation, client care and/or financing.

## Waiver 101

- The DMC-ODS is authorized as a demonstration waiver and DHCS is referring to the waiver overall as a pilot project.
- It is an amendment to the broader Medi-Cal 2020 health care services waiver.
- This waiver runs through 2020 and can be renewed at that time.

## Waiver 101

- Under this waiver, Counties will be able to set provider reimbursement rates and increase access to SUD treatment services for adolescents and adults who are Medi-Cal eligible.

- In addition, Counties and providers will be subject to a new set of clinical, administrative and financing requirements based in federal regulation.

## Phase I Update

- The Waiver is being implemented in phases:

  Phase I – Bay Area
  Phase II – Southern California
  Phase III – Central Valley
  Phase IV – Northern California
  Phase V – Indian Tribes and Indian Health Service

## Phase I Update

- At present 4 Counties have implementation plans submitted to DHCS
- Plans will be reviewed by DHCS and CMS
- Financial details are not yet clear; specifically
  - the Certified Public Expenditure (CPE) protocol
  - the State General Fund (SGF) contribution

## Phase I Update

- Some information will be forthcoming shortly –
  - DHCS Fiscal Plan should be out in a couple of weeks
    - This will ask Counties for provider rates and documentation on how they were developed.
  - CPE Protocol approval is expected from CMS within a few weeks.
- However, the particulars on SGF funding may not be available until the Governor's Budget for Fiscal Year 16-17 is introduced in early January 2016.

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## DHCS Update

- Provider Enrollment Division (PED) staffed up to handle increased demand for certification.
  - <45% of outpatient providers are DMC certified
  - <1% of residential providers are DMC certified.
- 72 providers have ASAM levels assigned, with another 100+ in the pipeline.
- External Quality Review Organizations (EQRO) and Training and Technical Assistance contracts have been awarded.

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## EQRO Responsibilities

- EQRO responsibilities include:
  - Assessment of County DMC-ODS plans' access and health information system (HIS) capabilities.
  - Development and implementation of quality of care performance measures (PM).
  - Develop County DMC-ODS plans' performance improvement projects (PIP) guidelines.

## More EQRO Responsibilities

- Include a diverse group of consumers and family members on the County review teams as part of the onsite review team
- Provide assurances that DMC-ODS quality requirements are being met.
- Examination of State and County consumer satisfaction surveys.

## And Still More EQRO

- Examine Federal Data Integrity Requirements for Health Information Security (HIS), including:
  - Verifying the accuracy and timeliness of data reported to, and by County DMC-ODS plans;
  - Screening provider and County DMC-ODS data for completeness, logic, and consistency;
  - Collecting service information reported by providers and County DMC-ODS plans in standardized formats to the extent feasible and appropriate.

## What will be happening around CA in 2016

- Selective Contracting Process
- Transition to DMC as primary funding for SUD treatment.
- Migration of SAPT funds to other purposes, e.g., recovery residences.
- Formation of regional provider networks
- Development/expansion of youth treatment services.
- Changes in  business model related to DMC financing and utilization management.
- Change in clinical models relative to EBPs, MAT and greater integration with primary care and MH.

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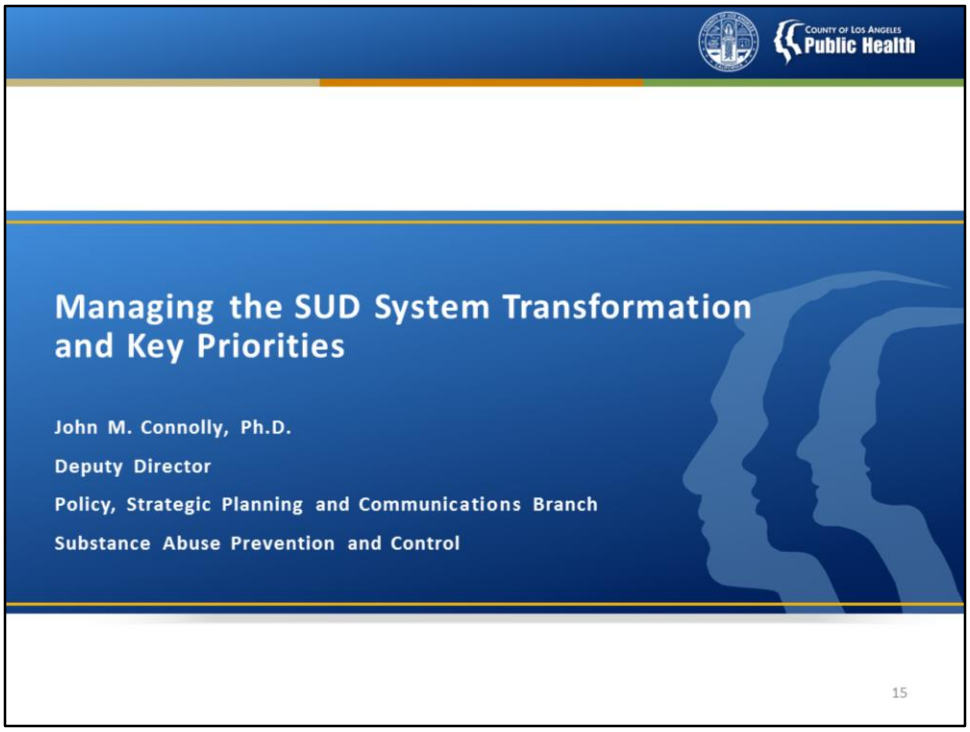
## For More Information:

CIBHS
CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS
LEADERS IN POLICY, TRAINING, EVALUATION AND RESEARCH

vkogler@cibhs.org


County of Los Angeles
Public Health
Managing the SUD System Transformation and Key Priorities
John M. Connolly, Ph.D.
Deputy Director
Policy, Strategic Planning and Communications Branch
Substance Abuse Prevention and Control
15

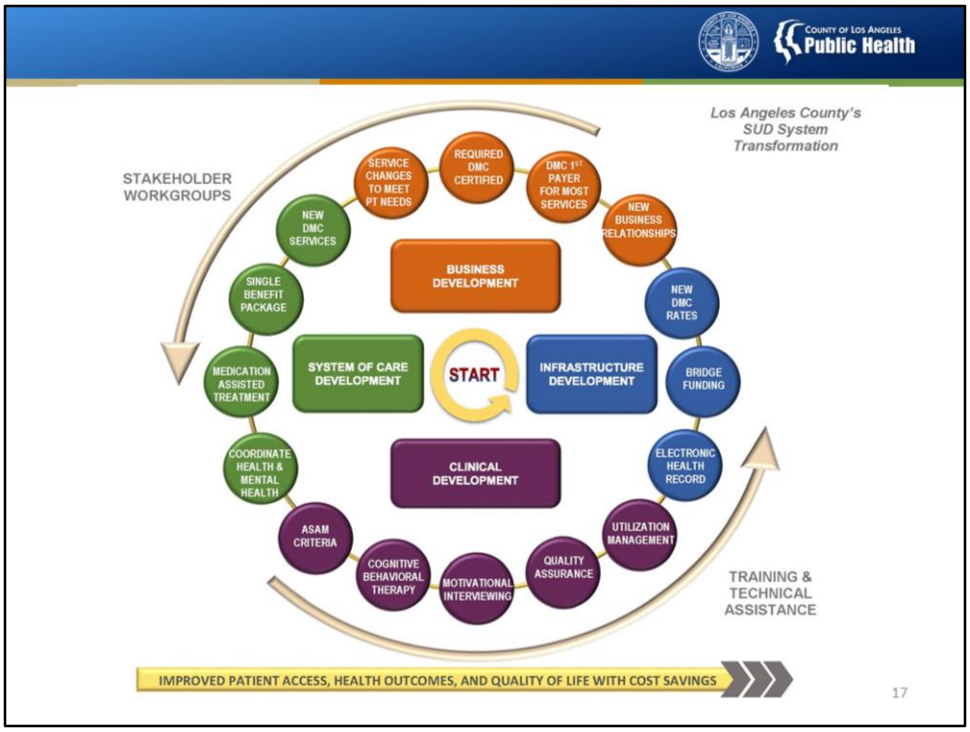

**The SUD Organized Delivery System Waiver comes with significant opportunities to improve our system of care, but also comes with significant expectations of our providers.**

New opportunities to provide better care for our clients include: The provision of case management, care coordination both within the SUD system and with other systems such as health and mental health, recovery support services, physician consultation services for DMC physicians, and enhanced access to medication-assisted treatment.

The higher expectations of our providers include: Required use of evidence-based practices (EBP) such as Motivational Interviewing and Cognitive Behavioral Therapy, required use of the ASAM Criteria and DSM-5 diagnoses to determine medical necessity and the appropriate level of care, and enhanced documentation that is more detailed and frequent than previously provided.

**The SUD Organized Delivery System Waiver is an unprecedented opportunity to truly transform and upgrade our system of care, and its success will depend heavily on SAPC and its providers to effectively work together to serve our patients.**

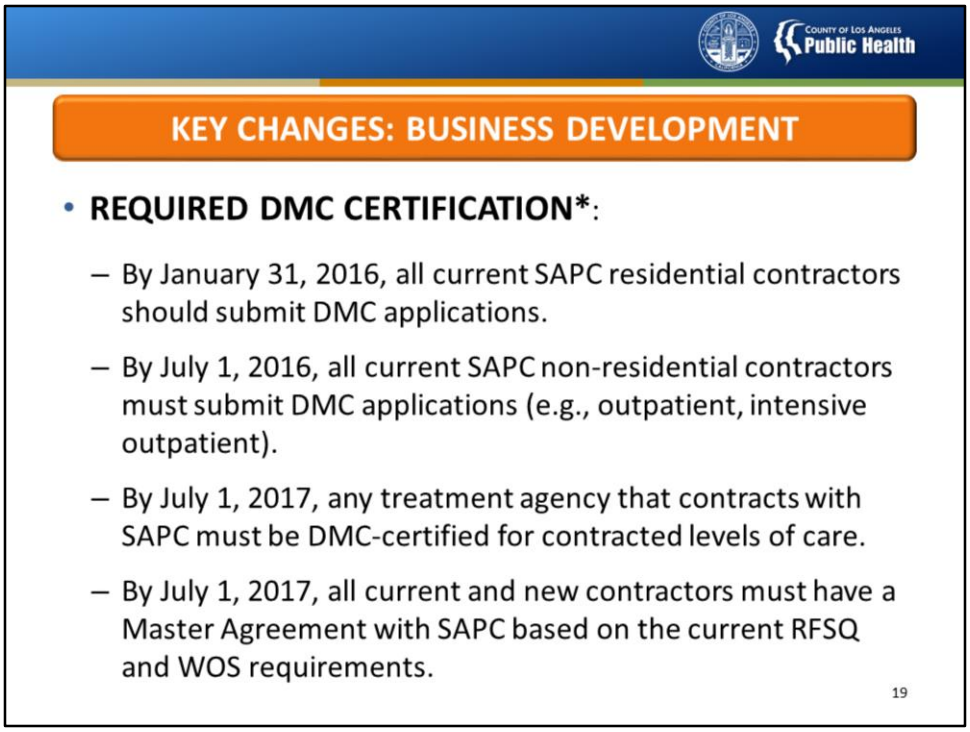
SAPC is fully committed to do what it can to ensure providers have the tools in terms of training, finances, and support to accomplish the goals of the SUD Organized Delivery System Waiver, and will rely on its providers for their active participation in this process. SAPC will be holding various workgroups focused on several key aspects of the waiver in the coming months, and will rely on providers to attend and participate so they can help to shape and build our redesigned system of SUD care.




Note: Not all key elements in the diagram will be expanded upon in this presentation.

## KEY CHANGES: BUSINESS DEVELOPMENT

- **SERVICE CHANGES TO MEET PATIENT NEEDS**:
  - Patients will have more opportunities to decide which provider best meets their needs, and choose accordingly.
  - Services need to be patient-centered versus program-centered (e.g., no pre-defined number of sessions).
  - Agencies can expand field-based services, business hours, days of operation, and otherwise tailor the program to better match patient preferences.

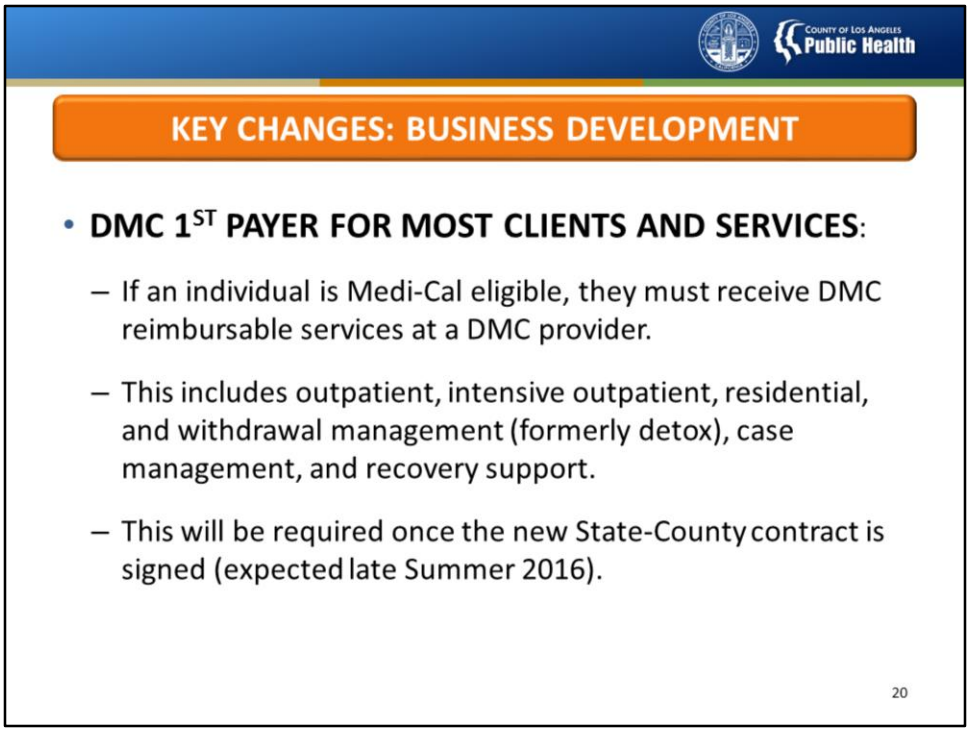



**DMC Application Submission:** The January and July 2016 deadlines were selected based on anticipated processing times by DHCS and to better ensure that applications are DHCS approved by the July 2017 County deadline. Agencies are strongly encouraged, however, to submit their application(s) before these dates to maximize their ability to provide new services. In addition, Phase 3 Counties will soon be allowed to submit new applications which could impact processing time.

**Certification Deadline:** If a current provider is not DMC certified for contracted levels of care by July 2017, they will no longer be able to contract with SAPC to provide SUD treatment services. This also applies to agencies who are seeking new contracts to provide SUD services.

**Master Agreement:** In addition to DMC certification, all agencies seeking to obtain or maintain a contract with SAPC must be on the Master Agreement List, and qualify under the current Request for Service Qualifications (RFSQ) and appropriate Work Order Solicitations (WOS). More information on the RFSQ/WOS process will be distributed soon.

* Treatment services only (does not apply for prevention services)



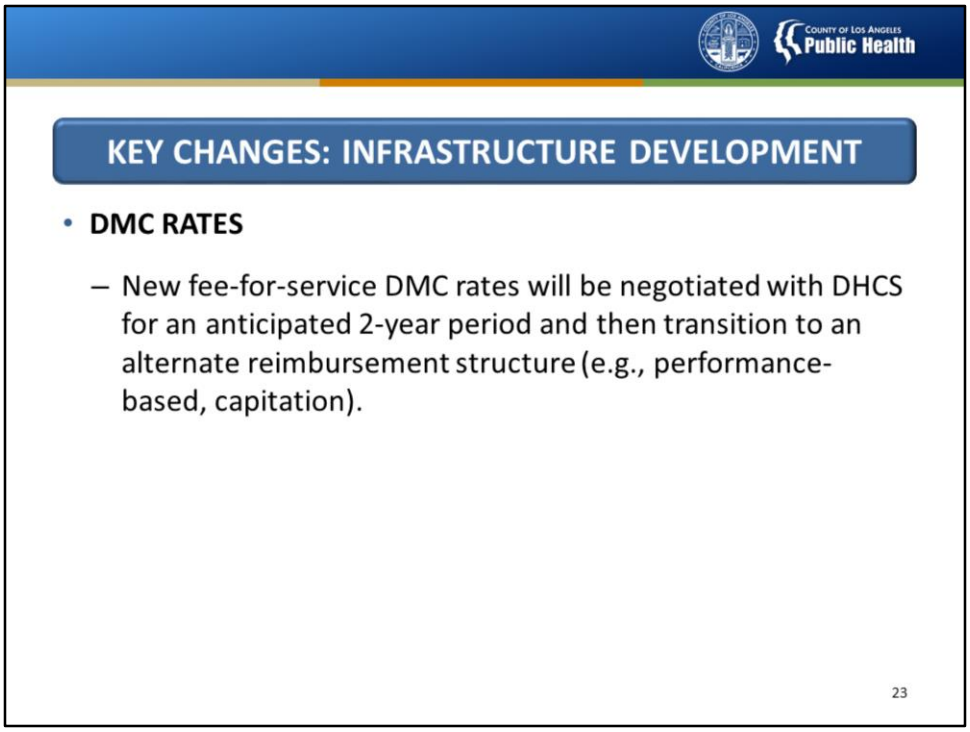

**DMC will be the primary funding source for our entire system of care moving forward.** As a result, the Organized Delivery System Waiver pertains to changes that will impact every single SUD provider within our network.

## KEY CHANGES: BUSINESS DEVELOPMENT

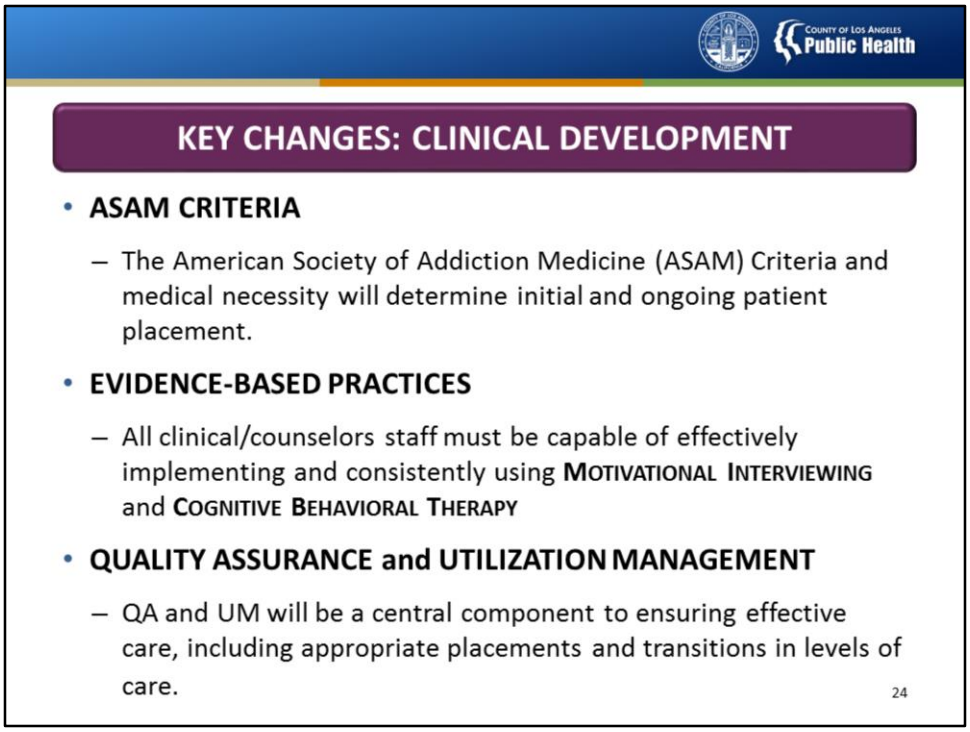
- **NEW BUSINESS RELATIONSHIPS**:
  - Regional networks will become more important as the new system transformation takes place over the next three years.
  - Developing formal business relationships with other providers may be helpful for particularly small- and medium-sized agencies to cover cost of new infrastructure requirements (e.g., medical directors, quality assurance programs).

## KEY CHANGES: SYSTEM OF CARE DEVELOPMENT

- **MEDICATION-ASSISTED TREATMENT (MAT)**:
  - MAT needs to be explored as a treatment option for patients with alcohol and/or opioid addictions.
- **COORDINATE HEALTH AND MENTAL HEALTH SERVICES:**
  - Care coordination and case-management will include ensuring necessary collaboration and connections (e.g., attended appointments) with physical and mental health services.

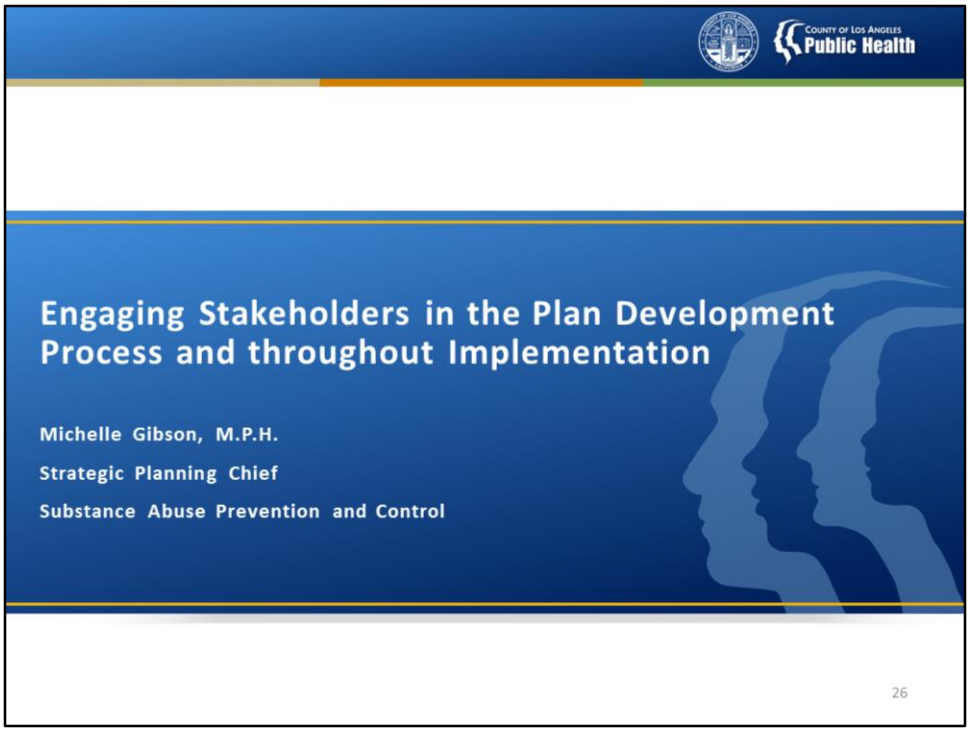



**A key SAPC priority is to determine and secure rates that will support the enhanced expectations of the SUD Organized Delivery System Waiver.** SAPC is able to negotiate with the State on the DMC rates that will be the primary funding source of SUD services in LA County. These higher DMC rates would help to enhance our workforce and services, and also help to encourage new providers to become DMC certified so that we can grow our provider capacity and improve access to SUD services, particularly in medical detox and residential settings. *See presentation by Patrick Gautier for more information on the methodology.*




**<u>CLINICAL DEVELOPMENT</u>: To ensure positive health outcomes for patients the waiver requires implementation of new clinical standards and management practices.** This includes requires use of the ASAM Criteria to determine placement at the appropriate level of care based on medical necessity, use of two DHCS selected EBPs (in Los Angeles County this is Motivational Interviewing and Cognitive Behavioral Therapy), and implementation of Quality Assurance and Utilization Management programs. *See presentation by Gary Tsai for more information on the methodology.*


Essential to the success of this system transformation will be the stakeholder workgroups, and on-going clinical and business capacity building to support providers in this significant transformation.


County of Los Angeles
Public Health
Engaging Stakeholders in the Plan Development Process and throughout Implementation
Michelle Gibson, M.P.H.
Strategic Planning Chief
Substance Abuse Prevention and Control
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## PREVIOUS STAKEHOLDER OPPORTUNITIES

### KICK-OFF MEETING — AUGUST 13, 2015

SUBSTANCE ABUSE PREVENTION AND CONTROL — ALHAMBRA

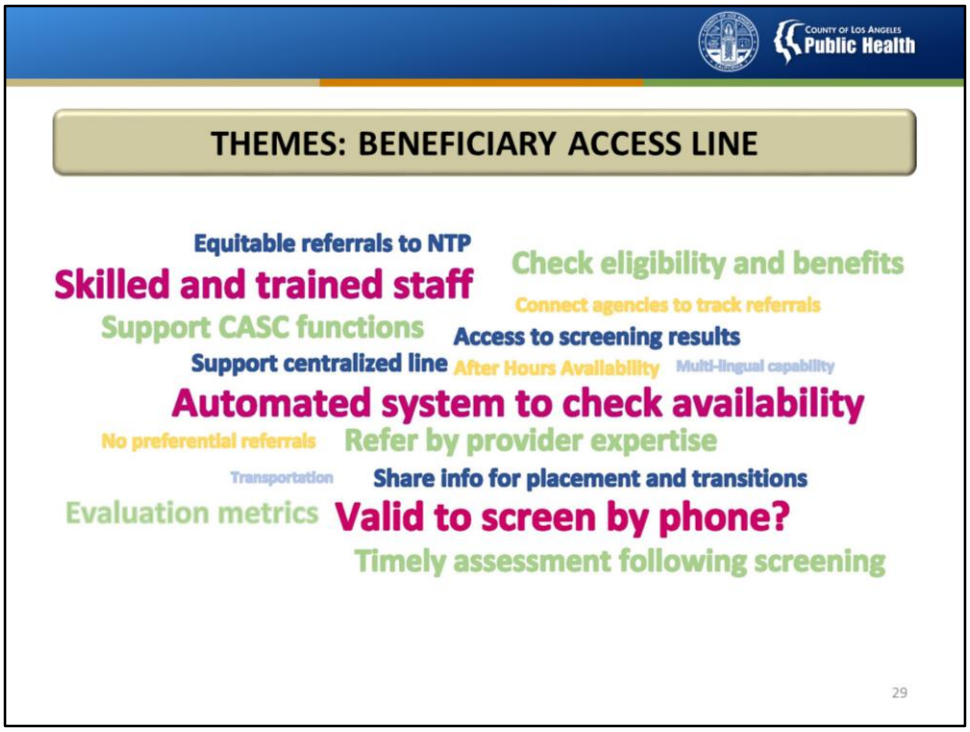
### REGIONAL MEETINGS — AUGUST 19 – SEPTEMBER 9, 2015

| | |
|---|---|
| MLK COMMUNITY ENGAGEMENT CENTER | WILMINGTON |
| DEPARTMENT OF HEALTH SERVICES | COMMERCE |
| HIGH DESERT MEDICAL CENTER | LANCASTER |
| BEHAVIORAL HEALTH SERVICES | GARDENA |
| PHOENIX HOUSES OF LOS ANGELES | LAKEVIEW TERRACE |
| ARCADIA PARK | ARCADIA |
| BURTON CHASE PARK | MARINA DEL REY |
| EAGLE ROCK LIBRARY | LOS ANGELES (EAGLE ROCK) |

### ONLINE SURVEY

## COUNTY PARTNERS AND HEALTH PLANS MEETING

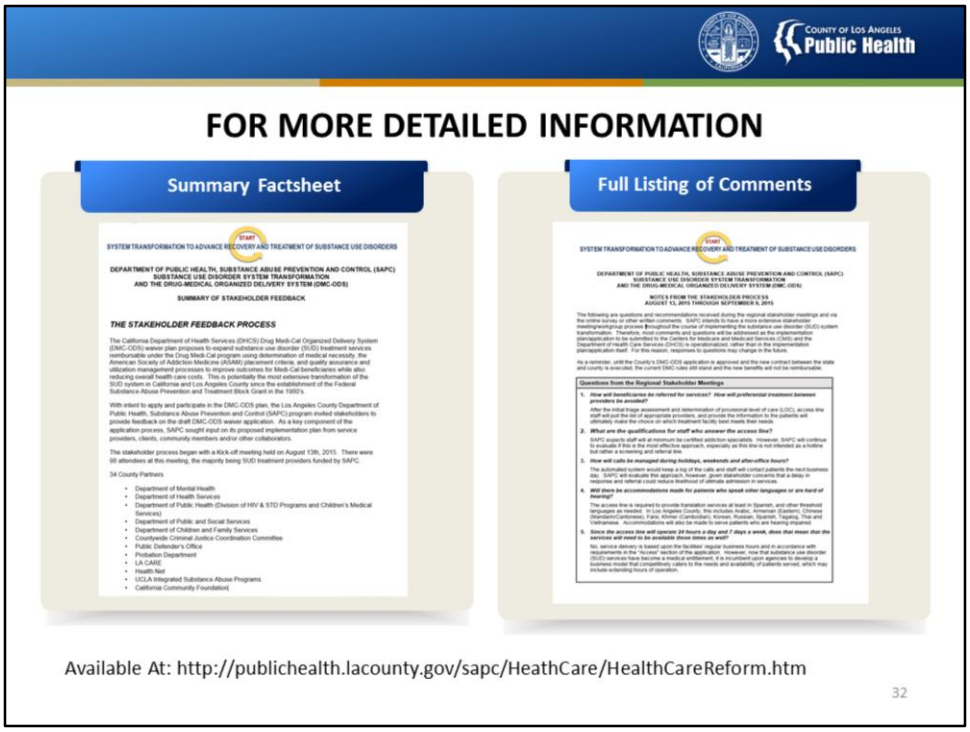
- Department of Mental Health
- Department of Health Services
- Department of Public Health (DHSP and CMS)
- Department of Public and Social Services
- Department of Children and Family Services
- Countywide Criminal Justice Coordination Committee
- Public Defender's Office
- Probation Department
- LA CARE
- Health Net
- UCLA Integrated Substance Abuse Programs
- California Community Foundation




The majority of comments received were on three topics: beneficiary access line, benefit package and residential authorizations. Key issues raised are highlighted in these figures – the larger the font, the more frequently an issue was raised.

# THEMES: BENEFIT PACKAGE

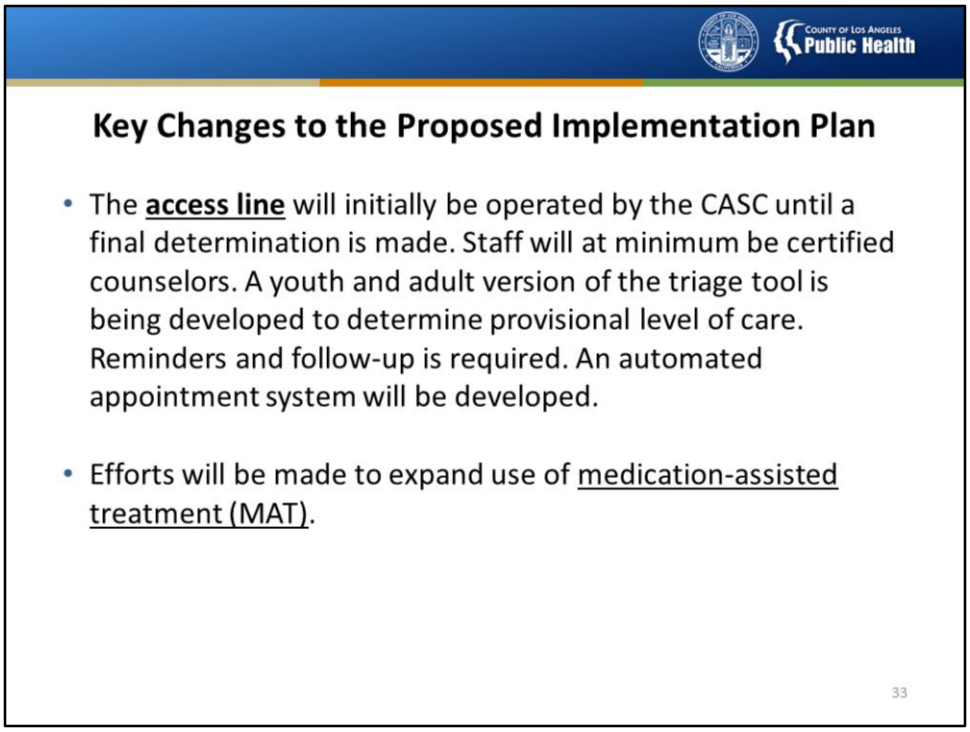
# THEMES: RESIDENTIAL SERVICES




The *Summary of Stakeholder Feedback* document provides summary feedback from the in-person meetings and the online survey. It also includes tables on the degree to which survey participants felt a topic was adequately addressed in the implementation plan.

The *Comments and Questions from the Stakeholder Feedback Process* document provides full detail of comments received from the in-person meetings and the online survey, and initial responses to questions received.

Both documents are posted on SAPC's website at the link provided on the slide.



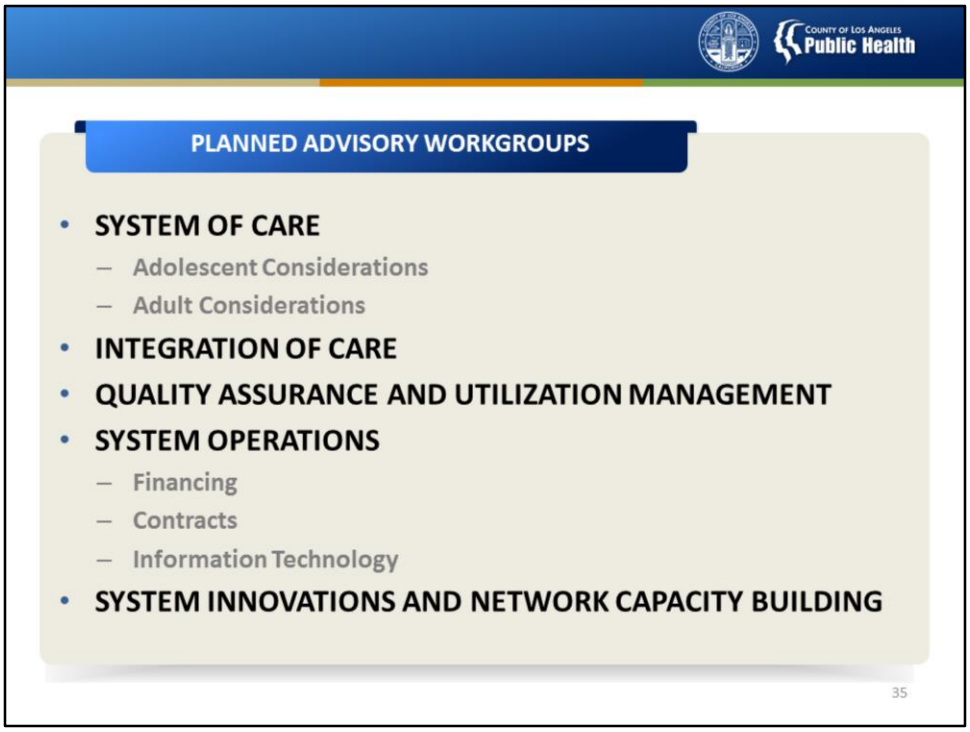

There were four key modifications to the August 10, 2015 version of the implementation plan. The plan will be reviewed and approved by DHCS and CMS so not all information in the plan will be accepted and additional modifications may be required. Most clinical and operational issues will be further defined after submission of the implementation plan to DHCS and CMS in early 2015.

## Key Changes to the Proposed Implementation Plan

- **Initial Authorization**: Residential providers willing to take the financial risk may admit patients pending County authorization determination, and may retroactively bill to date of admission if approved.

- **Continuing Authorization**: Residential cases will be reviewed by UM staff to monitor progress and ensure continued appropriateness of this level of care.

  Providers are expected to monitor progress throughout the patients' stay to ensure a transition to a lower level of care when clinically indicated, even if prior to completion of the approved authorization period.

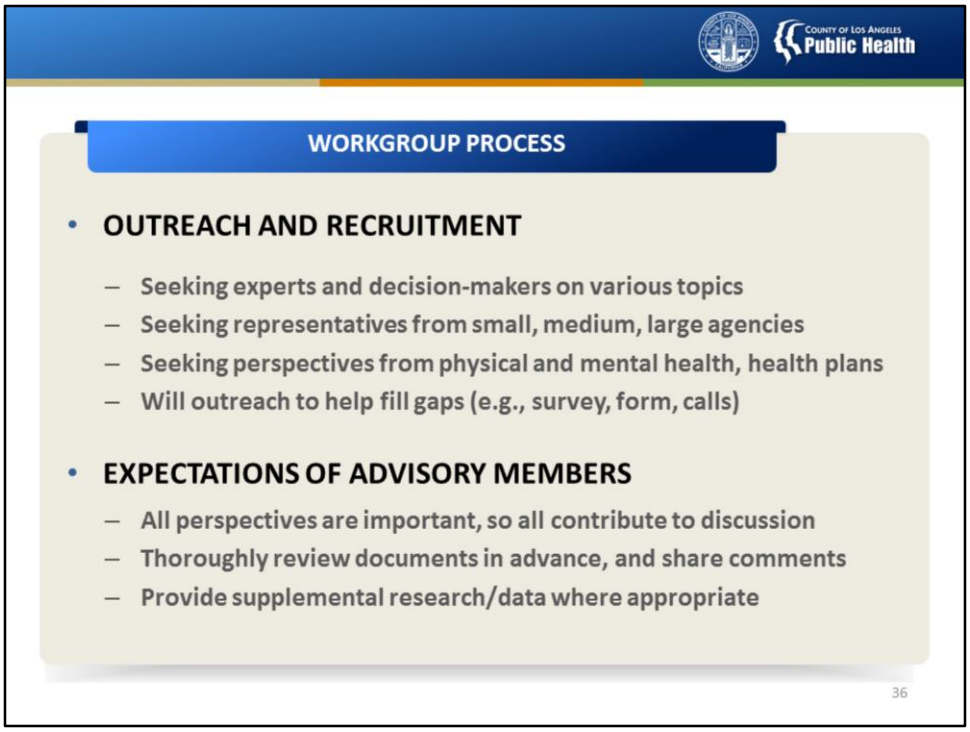



The implementation plan reviewed by stakeholders in August/September is the outline for Los Angeles County's SUD system transformation, and was drafted to meet the terms and conditions of the waiver. The detail of these changes will be determined during the implementation phase (beginning January 2016), and include collaboration with stakeholders through the advisory workgroup process. SAPC will prioritize advisory workgroup topics based on what needs to be achieved upon approval of SAPC's plan and execution of the new State/County contract by the Board of Supervisors (expected late Summer 2016) and what can be phased in during year one through three. To prepare for these workgroups, SAPC will conduct background research (e.g., review efforts in other jurisdictions/departments and best practices), develop the proposed model/plan, and obtain stakeholders feedback.

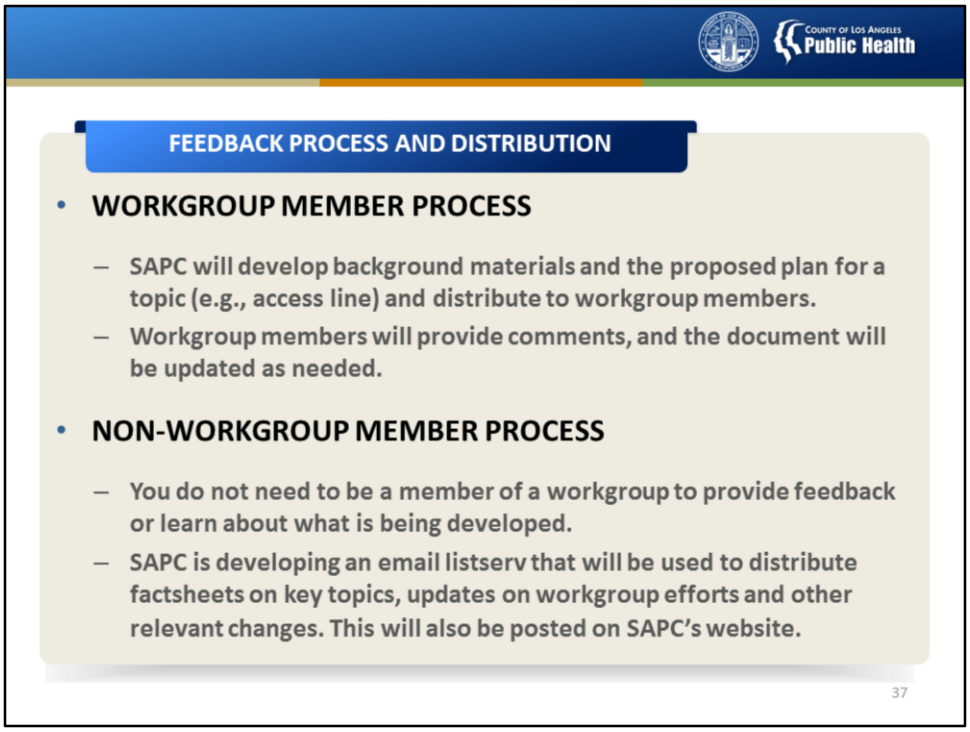
1. SYSTEM OF CARE will address how new services will be designed and expected clinical practices. Depending on the topic, adolescent and adult considerations may be discussed separately or jointly. The goal, however, is to develop one system of care for all individuals served.
2. INTEGRATION OF CARE will address how to ensure that the physical and mental heath needs of patients are coordinated and addressed, including collaboration with the health plans and related County departments.
3. QA/UM will address development of SAPC plan (currently reviewed via LACES Advisory Group), and expectations of SUD network agencies.
4. SYSTEMS OPERATIONS will address how new expectations developed in

collaboration with the System of Care, Integration of Care and QA/UM Advisory Workgroups will be operationalized. SAPC intends to have finance, contracts and IT staff attend other relevant workgroups regularly to provide guidance on what is feasible early in the development process. Therefore, this group may not meet as frequently or as early in this process.

5. SYSTEMS INNOVATIONS AND NETWORK CAPACITY BUILDING will take a more global look and what is needed to transform the SUD system to a specialty health plan model, and what efforts are needed to fully support developing the necessary business and clinical capacity of the SUD provider network.




To develop the best SUD network for our patients, we will need to develop appropriate operational and clinical practices. This requires considering feedback from all participating agencies and individuals equally. Therefore, SAPC will actively seek participation not only from experts on a particular topic (e.g., access line, telehealth) but also those from organizations with special expertise and of varying size. To achieve this, SAPC will develop a recruitment process (e.g., develop a survey to learn more about agency and individual expertise and willingness to participate on specific topics, nomination form to highlight expertise of one's self or another, phone calls based on SAPC staff knowledge of the provider network) to ensure a well-rounded and informed workgroup. Participation will also be open to any SUD provider with interest, expertise and decision-making ability.

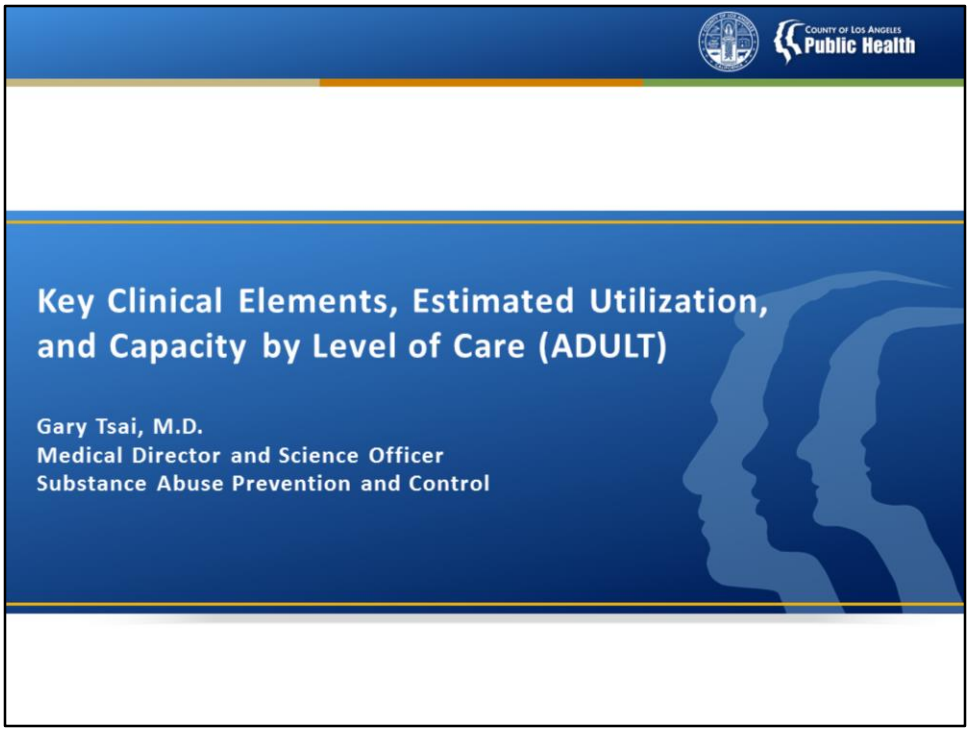



The advisory workgroups will be highly interactive discussions to review proposed plans, discuss opportunities and challenges for implementation and make modifications to best meet the needs of patients and achieve the objectives of the waiver. We recognize that agencies want to be informed but may not be able to send representatives to all meetings. Therefore, we are developing a process to ensure all providers can stay informed on these changes and contribute where able. This will begin with developing an email listserv that will be open to all individuals, regardless of their position within an organization. We will also regularly post updates to our website, including details on workgroup efforts. An email will be sent shortly on how to join the listserv (the initial email will be sent to those who have attended any stakeholder workgroup or are on another SAPC email list).

We expect the System of Care workgroup to be the first to start first in January/February 2016 since many issues need to be decided in time for the launch of Los Angeles County's participation in the waiver (expected late Summer 2016).

The success of this transformation, and ultimately the success of our patients, will depend on our collective ability to design, build and implement this new SUD system of care.

SAPC looks forward to extensive and ongoing collaboration with the SUD provider network and other stakeholders to develop this enhanced system of care, and supporting capacity building and infrastructure development efforts of the agencies providing these services.


County of Los Angeles
Public Health
Key Clinical Elements, Estimated Utilization, and Capacity by Level of Care (ADULT)
Gary Tsai, M.D.
Medical Director and Science Officer
Substance Abuse Prevention and Control

## Precision Addiction Medicine

- Overarching goal of an organized system of SUD care:
  - Right SERVICES
  - Right TIME
  - Right SETTING
  - Right DURATION


- Tailored treatment to individual need, as opposed to programmatic need

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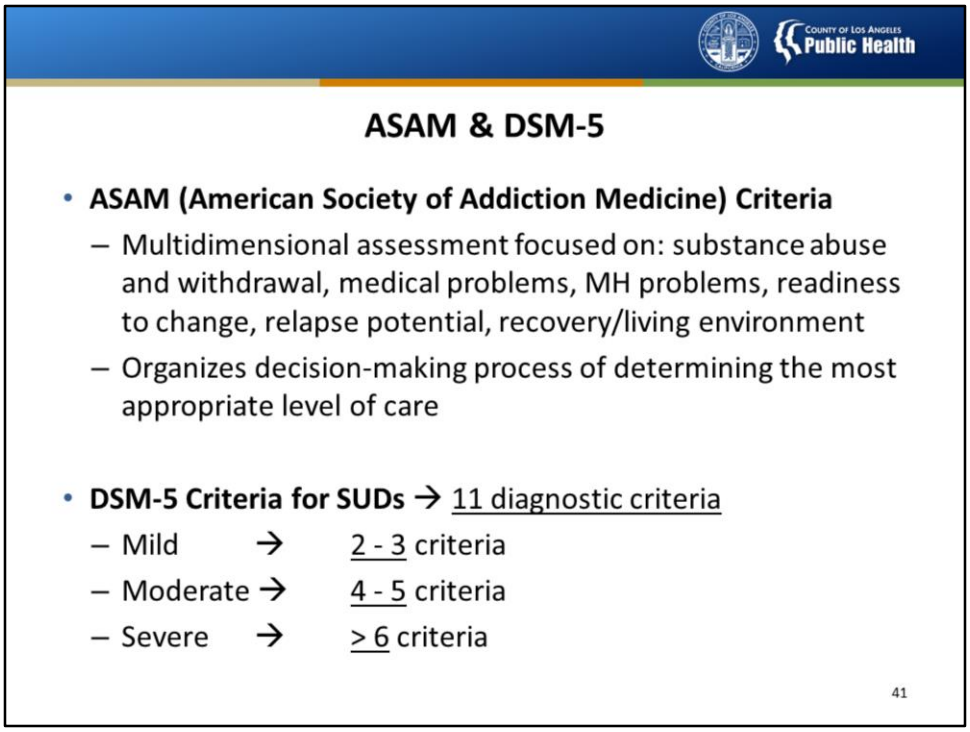
**The new system of care will be driven by client preference, with the goal of providing the RIGHT SERVICE, at the RIGHT TIME, in the RIGHT SETTING, for the RIGHT DURATION.** As much as possible and as clinically appropriate, services will be more patient-centered and less program-centered moving forward, meaning that the needs of the client rather than the needs of the program should drive care.




**The ASAM Criteria and DSM-5 will be the primary tool used to determine medical necessity and the appropriate level of SUD care moving forward.** While the ASAM Criteria will replace the Addiction Severity Index (ASI) as the primary SUD assessment tool in our system, there is significant overlap between the two and the ASAM Criteria should be familiar to most counselors and clinicians. All patients being treated in our system of care will need to have a DSM-5 diagnosis of at least one substance use disorder in order to establish medical necessity.

## How to Determine Medical Necessity

DSM-5 diagnosis of a substance use disorder

Appropriate level of care as determined by the ASAM Criteria

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**= MEDICAL NECESSITY**

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## Training

- **Priority 1 topics**:
  - ASAM Criteria / DSM-5 / Documentation
  - Motivational Interviewing
  - Cognitive Behavioral Therapy

  } Evidence-based practices

- **Priority 1.5 topics**:
  - Data Integrity
  - Cultural Competency
  - Co-Occurring Disorders, particularly Personality Disorders
  - Staff Burnout

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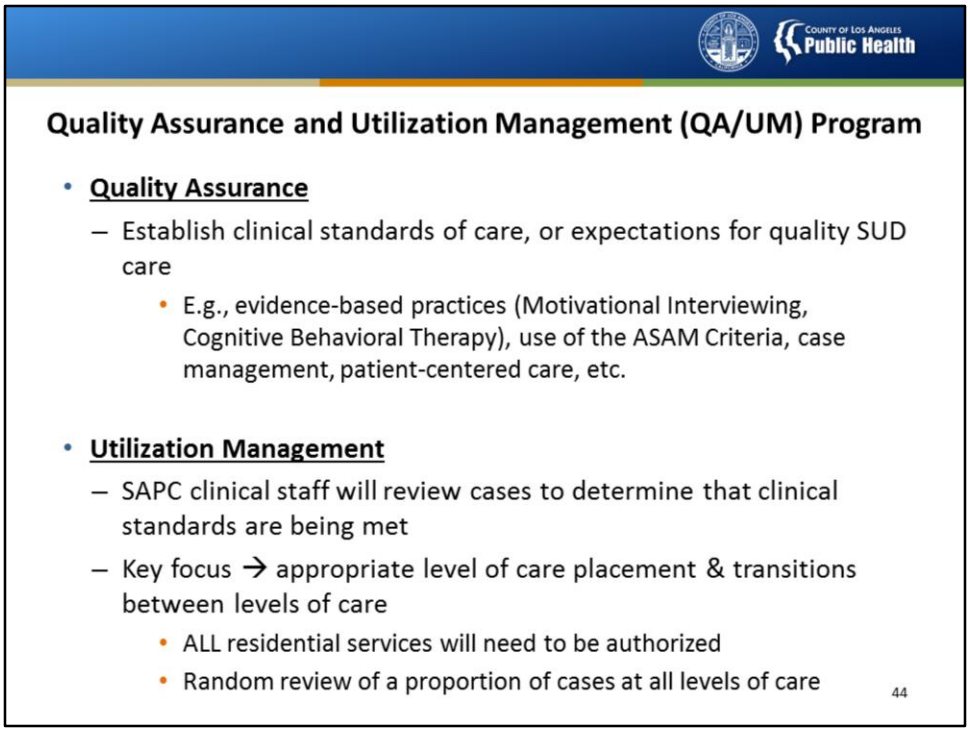
Upcoming trainings and other related resources are posted on SAPC's website: http://publichealth.lacounty.gov/sapc/Event/event.htm

SAPC will continue to support providers with trainings, but providers will also needs to ensure their staff are adequately trained and that knowledge gained from trainings is maintained through continued education and support.

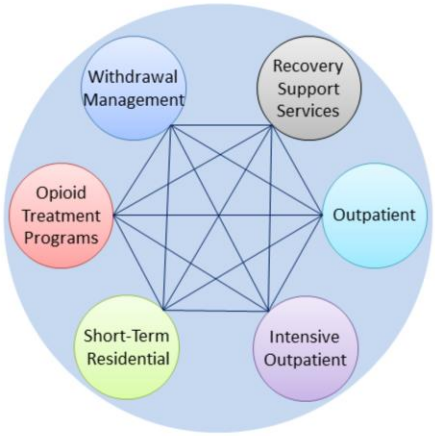



**Ensuring that clients use a fuller continuum of care within our system and resource management will be key focuses of this system transformation and the waiver.**

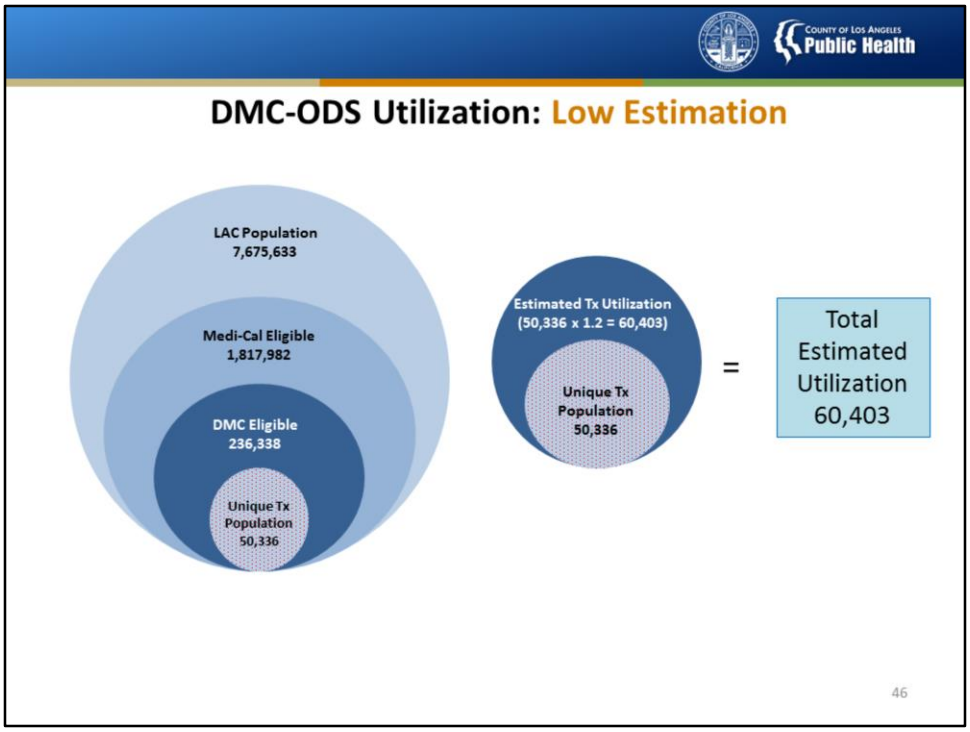
SAPC's Quality Assurance and Utilization Management team will be reviewing the care being provided by providers to ensure that it is consistent with recognized standards of practice, and will need to authorize all residential services. This will mean that some people will receive shorter lengths of stay in residential settings, but also that others will have more access to residential services if we can ensure an appropriate flow of clients through the various levels of care.

## Continuum of Care

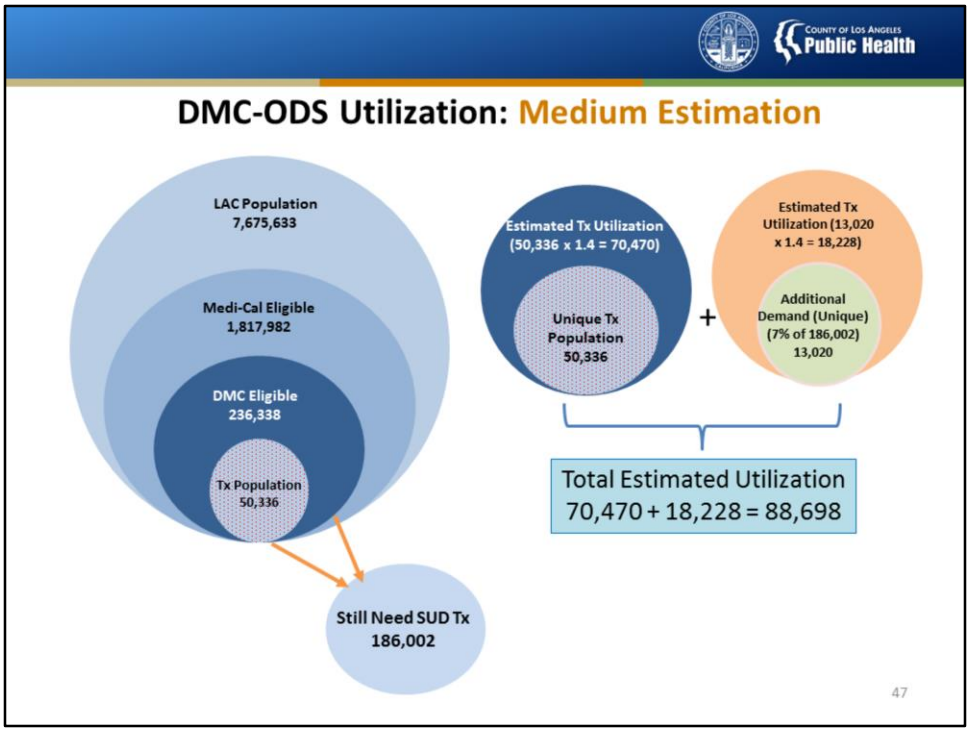
- Core elements of an effective SUD system of care
  - The use of the full continuum of care available to our patients
  - Fluid transitions between levels of care within that continuum



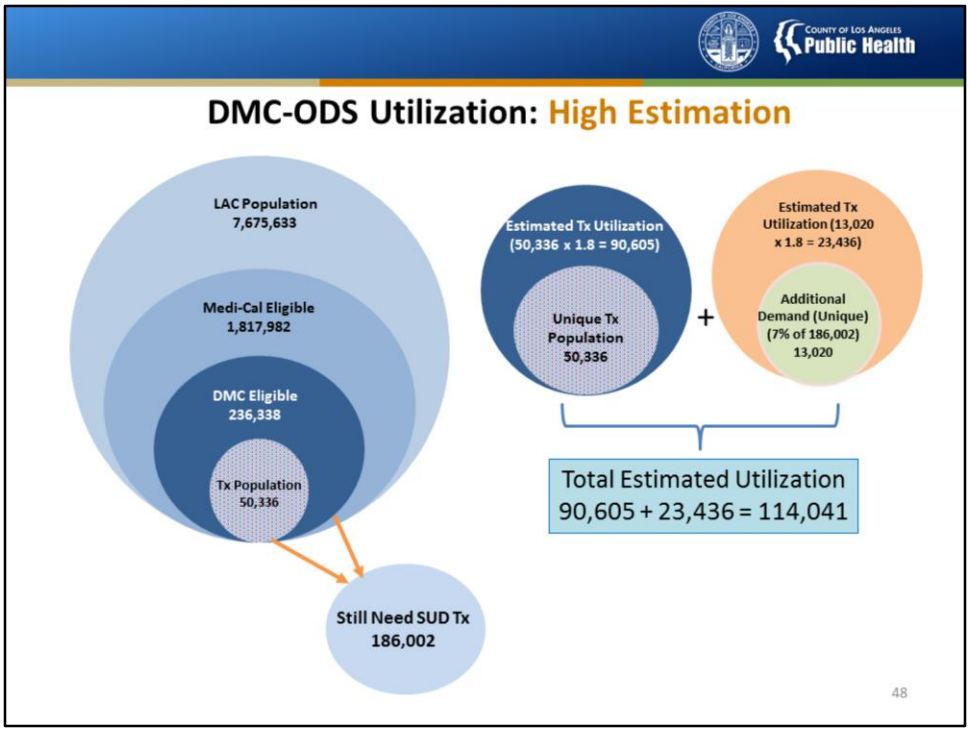

Done well, the end result will be services that are more tailored to individual need and more available to a greater number of people



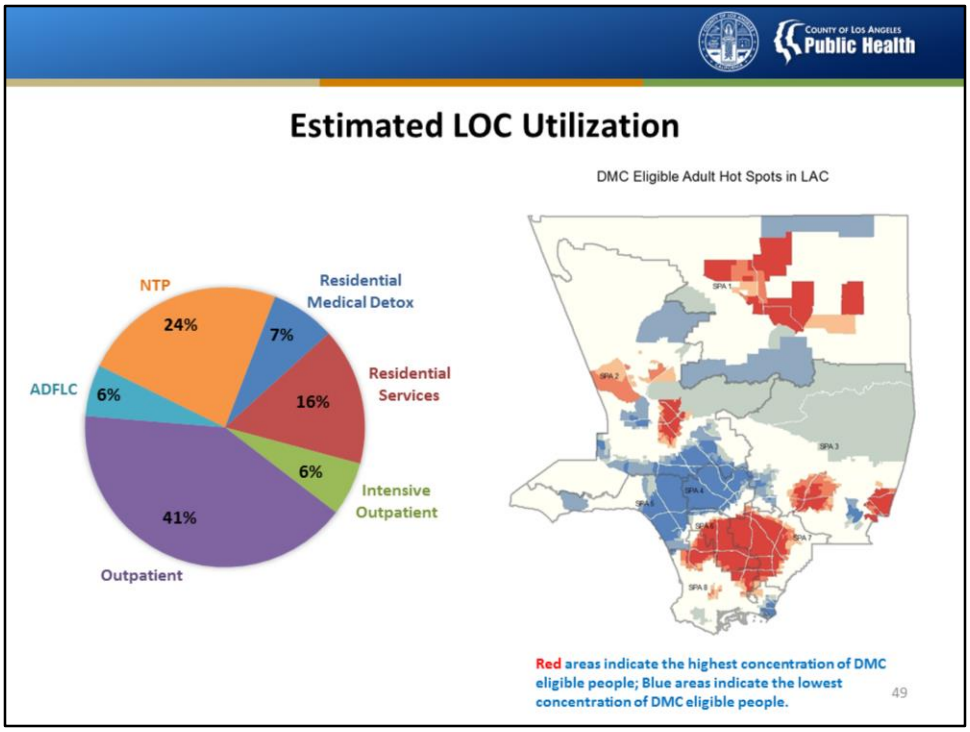

Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years; Average treatment utilization was 1.2 times per person; 50,336 x 1.2 = 60,403 will be the estimated low utilization (this is essentially the status quo)




Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years;
Medium estimation: unique clients (50,336) x average estimated continuum of care utilization of 1.4 readmissions per client with use of some levels of the continuum (greater utilization of the continuum of care [residential detox, residential, and outpatient] than currently, but less so than the high estimate)

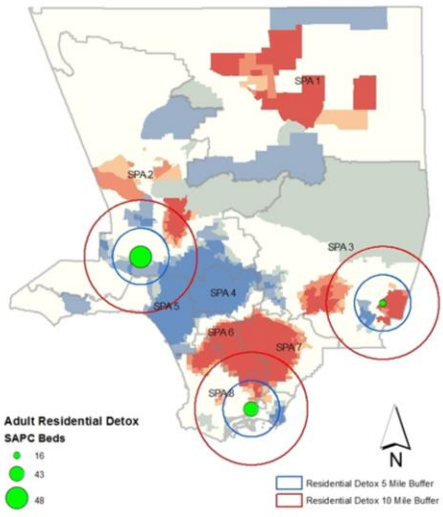



Treatment population (50,336) = average unique clients within and across LOC (non-repeated clients) per year during last 10 years;
Maximum estimation: unique clients (50,336) x average estimated continuum of care utilization of 1.8 readmissions per client (medical detox: 3 episodes, residential: 2 episodes, IOP: 2 episodes, OP: 1.5 episodes, and NTP: 1.8 episodes). This is a very optimistic/ideal estimation bc it is based on the assumption that most people will step down to the next level of care after completing the initial LOC, which would be a shift from the status quo.




Applied this adjusted % breakdown to all three levels (low, medium, & high) of estimation.

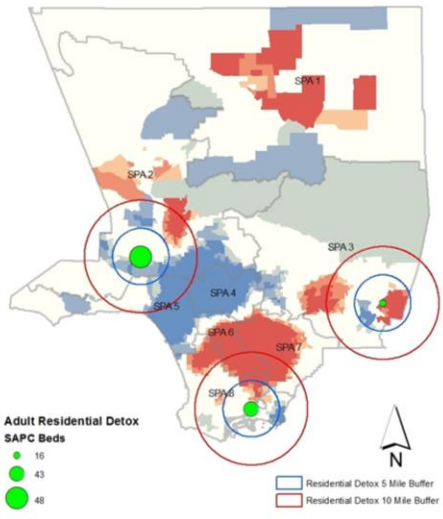
# Low: Residential Medical Detox Bed Capacity




| Residential Medical Detox Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 60,403 |
| Estimated residential medical detox utilization | 4,228 (7%) |
| Clients per bed per year | 40* |
| Total beds needed | 106 |
| SAPC bed capacity | 107 |
| Additional beds needed | 0 |
| Unfunded beds | 0 |
| Additional beds needed after using unfunded beds | 0 |
| Number of Residential Medical Detox Facilities | 3 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

# Medium: Residential Medical Detox Bed Capacity




| Residential Medical Detox Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 88,698 |
| Estimated residential medical detox utilization | 6,209 (7%) |
| Clients per bed per year | 40* |
| Total beds needed | 155 |
| SAPC bed capacity | 107 |
| Additional beds needed | 48 |
| Unfunded beds | 0 |
| Additional beds needed after using unfunded beds | 48 |
| Number of Residential Medical Detox Facilities | 3 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

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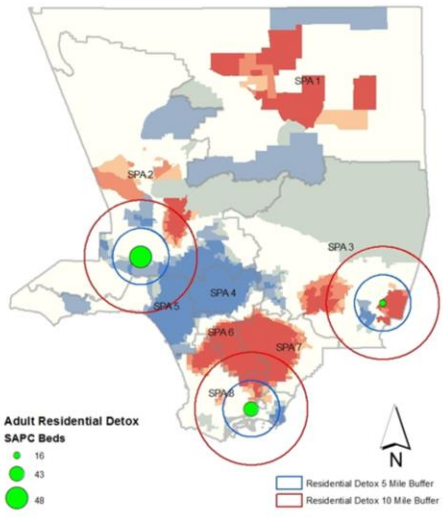
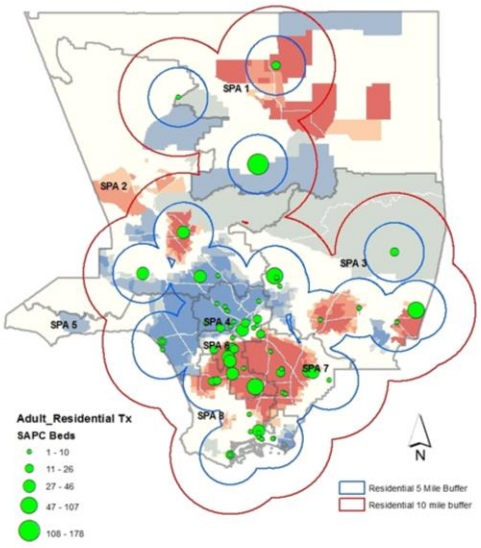
# High: Residential Medical Detox Bed Capacity




| Residential Medical Detox Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 114,041 |
| Estimated residential medical detox utilization | 7,983 (7%) |
| Clients per bed per year | 40* |
| Total beds needed | 200 |
| SAPC bed capacity | 107 |
| Additional beds needed | 93 |
| Unfunded beds | 0 |
| Additional beds needed after using unfunded beds | 93 |
| Number of Residential Medical Detox Facilities | 3 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 7 days (70%), 14 days (30%); that concluded roughly 40 clients per slot per year

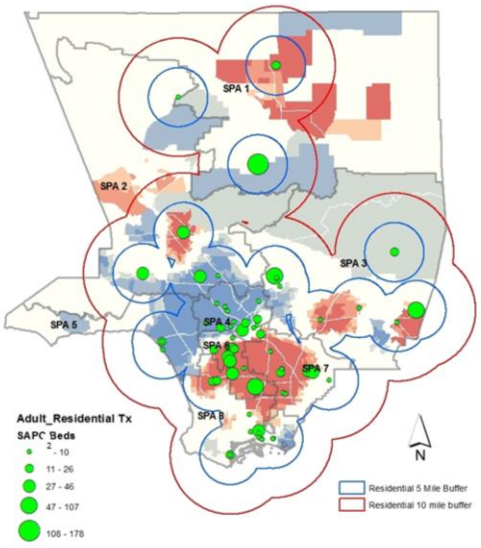
# Low: Residential Bed Capacity




| Residential Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 60,403 |
| Estimated residential utilization | 9,664 (16%) |
| Clients per bed per year | 6* |
| Total beds needed | 1,611 |
| SAPC bed capacity | 1,220 |
| Additional Beds needed | 391 |
| Unfunded beds | 697 |
| Additional beds needed after using unfunded beds | 0 |
| Number of Residential Facilities | 75 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)

# Medium: Residential Bed Capacity




| Residential Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 88,698 |
| Estimated residential utilization | 14,192 (16%) |
| Clients per bed per year | 6* |
| Total beds needed | 2,365 |
| SAPC bed capacity | 1,220 |
| Additional Beds needed | 1,145 |
| Unfunded beds | 697 |
| Additional beds needed after using unfunded beds | 448 |
| Number of Residential Facilities | 75 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)

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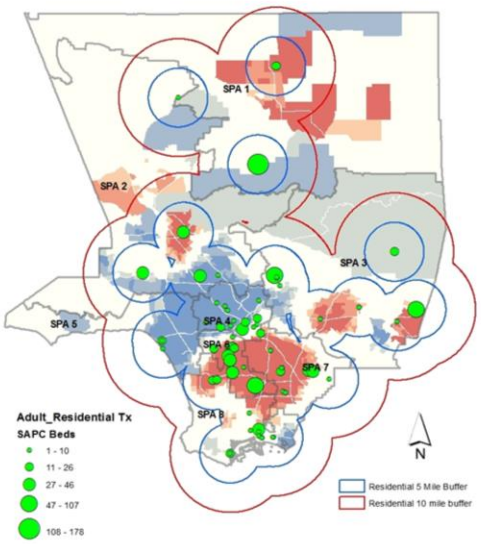
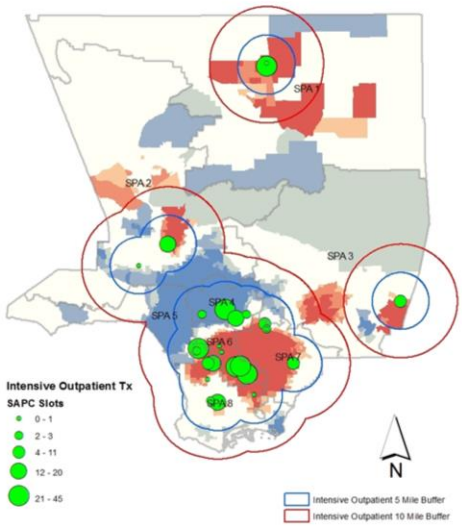
# High: Residential Bed Capacity




| Residential Bed Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 114,041 |
| Estimated residential utilization | 18,247 (16%) |
| Clients per bed per year | 6* |
| Total beds needed | 3,041 |
| SAPC bed capacity | 1,220 |
| Additional Beds needed | 1,821 |
| Unfunded beds | 697 |
| Additional beds needed after using unfunded beds | 1,124 |
| Number of Residential Facilities | 75 |

*Clients per bed per year was estimated based on the current length of stay utilization pattern: 30days (30%), 60 days (40%), 90 days (20%), 120 days (10%) that concluded roughly 6 clients per slot per year (5.8)

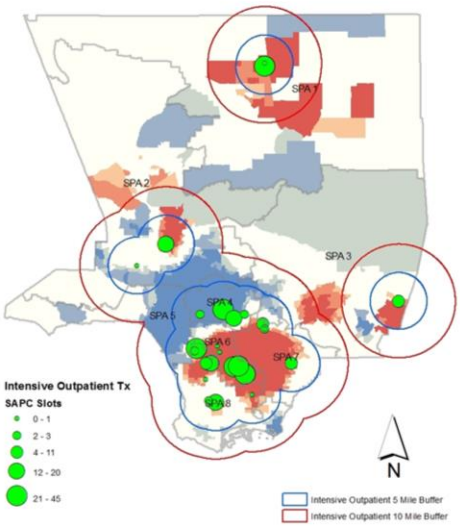
# Low: Intensive Outpatient (IOT) Slot Capacity




| IOP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 60,403 |
| Estimated IOP utilization | 3,624 (6%) |
| Clients per slot per year | 5* |
| Total slots needed | 725 |
| SAPC slot capacity | 375 |
| Additional slots needed | 350 |
| Number of IOP Facilities | 26 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay--60days (55%), 100 days (20%), 130 days (25%); Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)

# Medium: Intensive Outpatient (IOT) Slot Capacity




| IOP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 88,698 |
| Estimated IOP utilization | 5,322 (6%) |
| Clients per slot per year | 5* |
| Total slots needed | 1064 |
| SAPC slot capacity | 375 |
| Additional slots needed | 689 |
| Number of IOP Facilities | 26 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay--60days (55%), 100 days (20%), 130 days (25%); Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)

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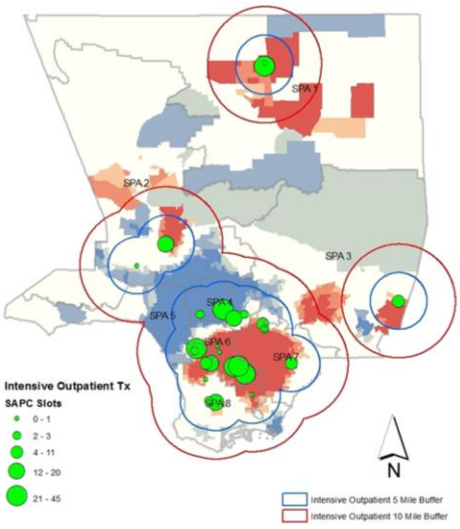
# High: Intensive Outpatient (IOT) Slot Capacity




| IOP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 114,041 |
| Estimated IOP utilization | 6,842 (6%) |
| Clients per slot per year | 5* |
| Total slots needed | 1,368 |
| SAPC slot capacity | 375 |
| Additional slots needed | 993 |
| Number of IOP Facilities | 26 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay--60days (55%), 100 days (20%), 130 days (25%); Days of services per week (up to 9-19 hours)—5 days (50%) 3 days (50%); roughly came out 5 clients per slot per year (5.3)

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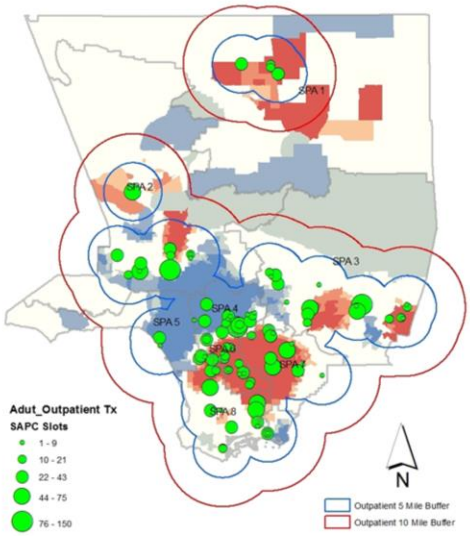
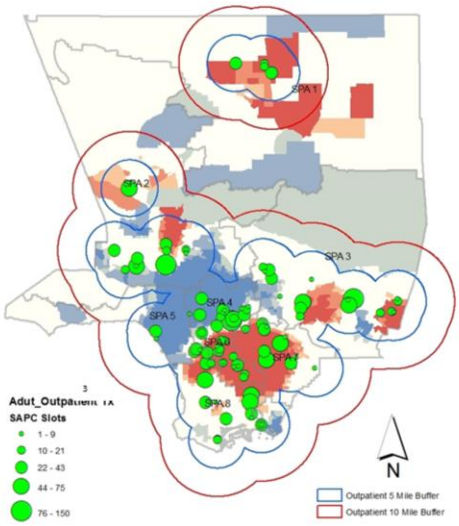
# Low: Outpatient (OP) Slot Capacity




| OP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 60,403 |
| Estimated OP utilization | 24,765 (41%) |
| Clients per slot per year | 7* |
| Total slots needed | 3,538 |
| SAPC slot capacity | 2,402 |
| Additional slots needed | 1,136 |
| Number of OP Facilities | 98 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)

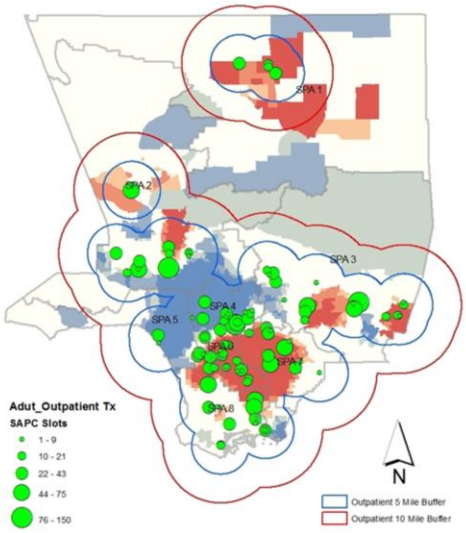
# Medium: Outpatient (OP) Slot Capacity




| OP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 88,698 |
| Estimated OP utilization | 36,366 (41%) |
| Clients per slot per year | 7* |
| Total slots needed | 5,195 |
| SAPC slot capacity | 2,402 |
| Additional slots needed | 2,793 |
| Number of OP Facilities | 98 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)

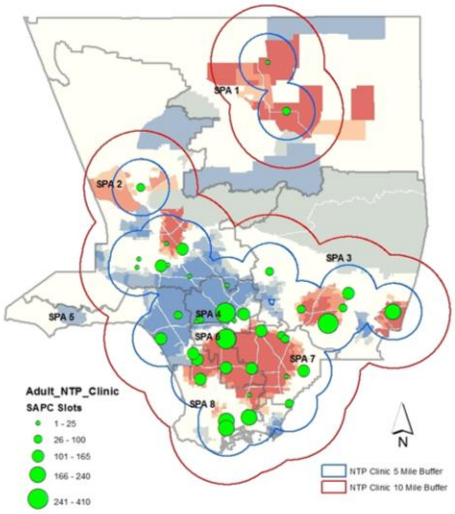
# High: Outpatient (OP) Slot Capacity




| OP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 114,041 |
| Estimated OP utilization | 46,757 (41%) |
| Clients per slot per year | 7* |
| Total slots needed | 6,680 |
| SAPC slot capacity | 2,402 |
| Additional slots needed | 4,278 |
| Number of OP Facilities | 98 |

* Clients per slot per year was estimated based on the current LOS utilization pattern: Length of stay of 60days (60%), 90 days (15%), 120 days (25%); Days of services per week (up to 9 hours)—5 days (30%), 3 days (50%), 1 day (20%); roughly came out 7 clients per slot per year (7.2)

# Low: Opioid Treatment Program (OTP) Slot Capacity




| NTP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 60,403 |
| Estimated NTP utilization | 14,497 (24%) |
| Clients per slot per year | 3* |
| Total slots needed | 4,832 |
| SAPC slot capacity | 5,373 |
| Additional slots needed | 0 |
| No of NTP Clinics | 39 |

* Clients per slot per year was estimated based on the current length of stay utilization pattern: 90days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year

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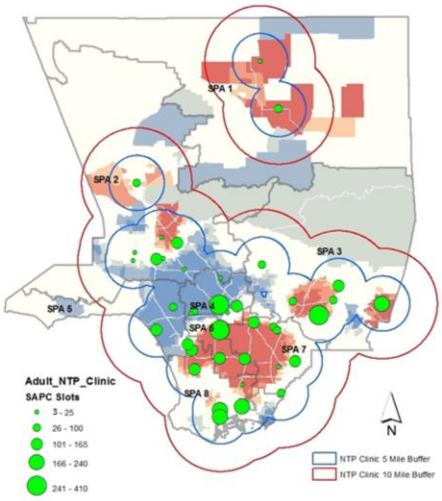
# Medium: Opioid Treatment Program (OTP) Slot Capacity




| NTP Slot Utilization and Capacity | Number |
|---|---|
| Total estimated utilization | 88,698 |
| Estimated NTP utilization | 21,288 (24%) |
| Clients per slot per year | 3* |
| Total slots needed | 7,096 |
| SAPC slot capacity | 5,373 |
| Additional slots needed | 1,723 |
| No of NTP Clinics | 39 |

* Clients per slot per year was estimated based on the current length of stay utilization pattern: 90days (30%), 120 days (20%), 150 days (30%), 180 days (20%) that concluded roughly 3 clients per slot per year

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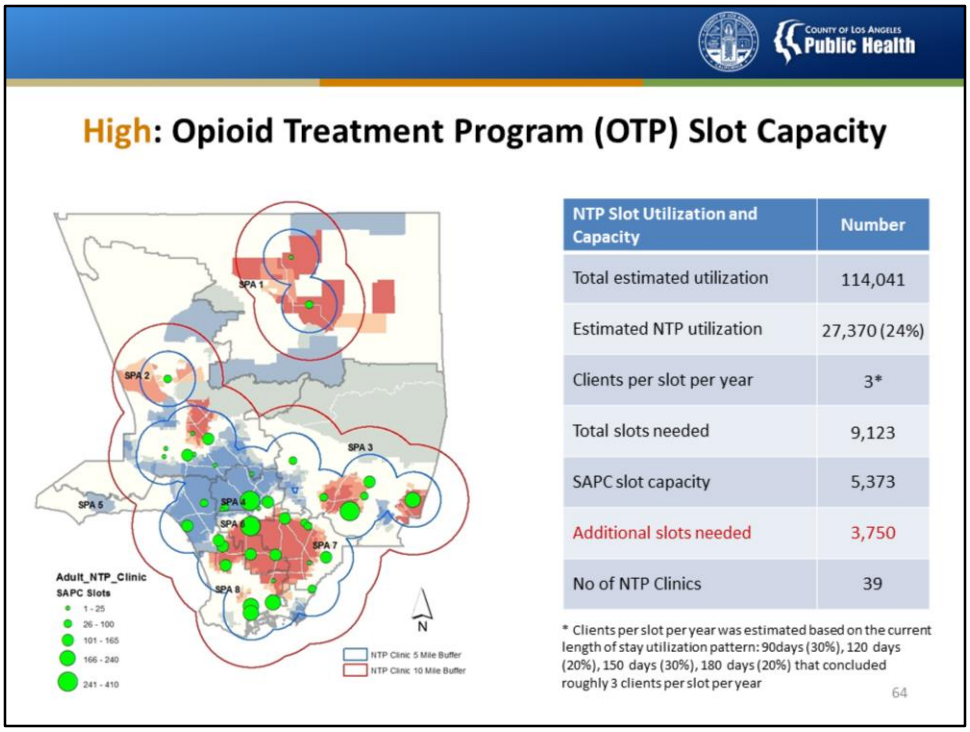


Overall, SAPC anticipates more people coming into our system of care as a result of numerous influences, and this will require us to expand our network capacity in order to accommodate these increased numbers while ensuring access to necessary SUD services.

- Improved SUD services that are more client-centered
- Streamlined access to services
- Greater outreach and messaging to the general public
- Greater recognition of the importance of addressing SUD in the health and mental health community, which should result in more referrals
- Treatment of SUD in the criminal justice setting, which should result in community referrals once they are released


County of Los Angeles
Public Health
Financing the DMC-ODS and Reimbursement
Patrick Gauthier
Director
Advocates for Human Potential (AHP) Healthcare Solutions
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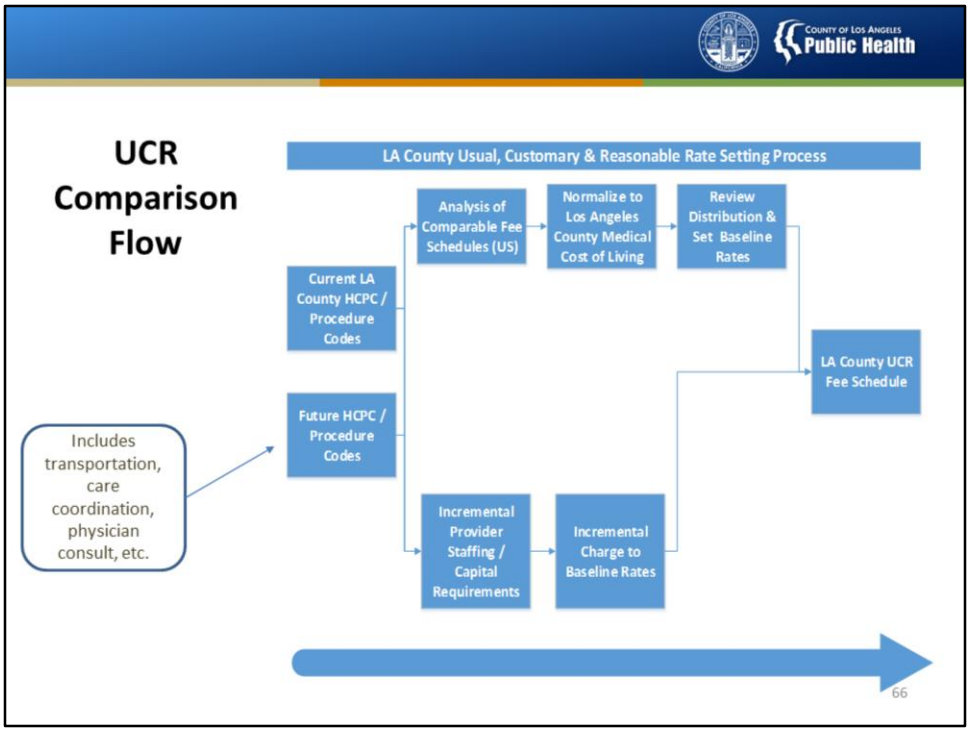
UCR Comparison Flow
LA County Usual, Customary & Reasonable Rate Setting Process
Analysis of Comparable Fee Schedules (US)
Normalize to Los Angeles County Medical Cost of Living
Review Distribution & Set Baseline Rates
Current LA County HCPC / Procedure Codes
LA County UCR Fee Schedule
Future HCPC / Procedure Codes
Includes transportation, care coordination, physician consult, etc.
Incremental Provider Staffing / Capital Requirements
Incremental Charge to Baseline Rates
66

## UCR Comparison Chart

| Usual, Customary & Reasonable Rate Setting Process Example | | | | | |
|---|---|---|---|---|---|
| HCPC / Procedure Code | | 99204 | H0004 | H0005 | H0015 |
| SAPC Rate | 100 | | | | |
| CA Medi-Cal Rate | 100 | | | | |
| Minesota Rate | 96 | | | | |
| Maryland Rate | 81 | | | | |
| Kentucky Rate | 86 | | | | |
| OR Rate | 98 | | | | |
| SC Rate | 94 | | | | |
| Average | | | | | |

- Rate Comparison Example

## UCR Comparison Chart

- Rate Comparison Example
- Maryland Rate for H0004 is $20
- LA cost of living adjustment moves Maryland rate to $24.69
- Analytic support to raise SAPC rate to $23 - $24

| Usual, Customary & Reasonable Rate Setting Process Example | | | | | |
|---|---|---|---|---|---|
| HCPC / Procedure Code | | 99204 | H0004 | H0005 | H0015 |
| SAPC Rate | 100 | 174.33 | 19.00 | 4.75 | 83.39 |
| CA Medi-Cal Rate | 100 | 68.90 | | | |
| Minesota Rate | 96 | | | 30.75 | |
| Maryland Rate | 81 | 200.16 | 24.69 | 16.05 | 154.32 |
| Kentucky Rate | 86 | | | 15.70 | 67.74 |
| OR Rate | 98 | 111.00 | 24.35 | 35.85 | 80.94 |
| SC Rate | 94 | 116.89 | 21.07 | | 139.96 |
| Average | | 124.24 | 23.37 | 24.59 | 110.74 |

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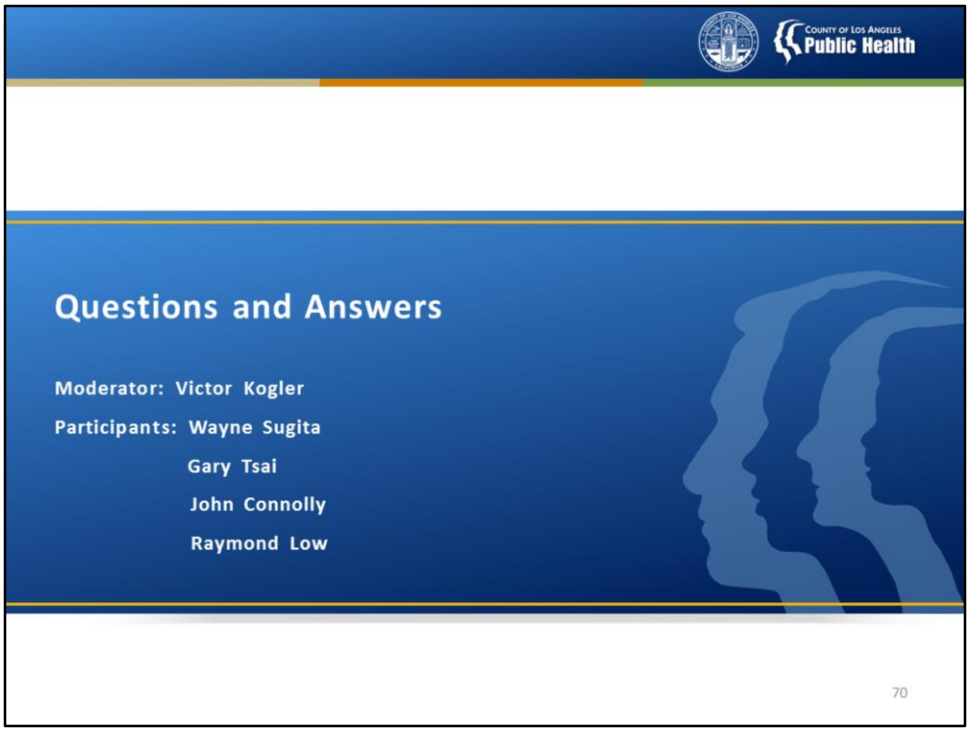
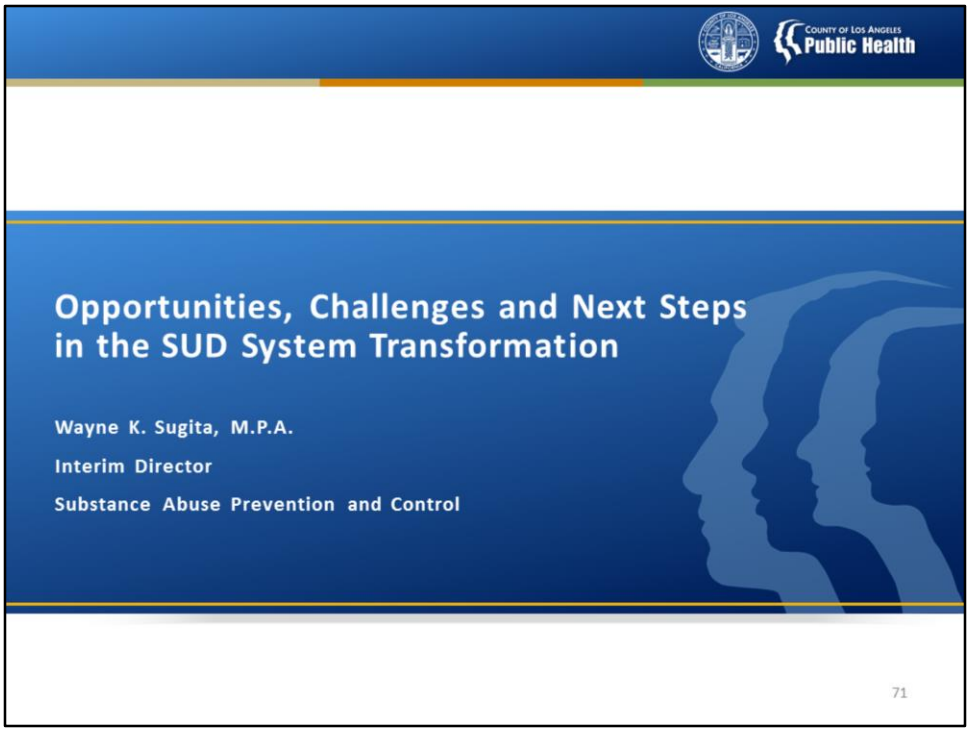
# Considering Shared Services and Administrative Functions in the new Organized Delivery System


County of Los Angeles
Public Health
Questions and Answers
Moderator: Victor Kogler
Participants: Wayne Sugita
Gary Tsai
John Connolly
Raymond Low
70


County of Los Angeles
Public Health
Opportunities, Challenges and Next Steps in the SUD System Transformation
Wayne K. Sugita, M.P.A.
Interim Director
Substance Abuse Prevention and Control
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# RELEVANT LINKS AND RESOURCES

**DHCS DMC General Information**
http://www.dhcs.ca.gov/services/adp/Pages/default.aspx

**DHCS DMC Certification Documents**
http://www.dhcs.ca.gov/provgovpart/Pages/DMC-Forms.aspx

**DHCS DMC Residential Certification Documents**
http://www.dhcs.ca.gov/provgovpart/Pages/FacilityLicensing.aspx

**SAPC SUD Master Agreement RFSQ (#2012-004)**
http://publichealth.lacounty.gov/cg/index.htm

**SAPC Clinical Trainings**
http://publichealth.lacounty.gov/sapc/Event/event.htm

**SAPC SUD System Transformation/Waiver Documents**
http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm