START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control

Implementation Plan for Drug Medi-Cal Organized Delivery System Waiver

Approved - July 27, 2016

County of Los Angeles Public Health
Substance Abuse Prevention and Control

PART I
PLAN QUESTIONS

1. ***Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.***

☒ County Behavioral Health Agency
☒ County Substance Use Disorder Agency
☒ Providers of drug/alcohol treatment services in the community
☒ Representatives of drug/alcohol treatment associations in the community
☒ Physical Health Care Providers
☒ Medi-Cal Managed Care Plans
☒ Federally Qualified Health Centers (FQHCs)
☐ Clients/Client Advocate Groups
☐ County Executive Office
☒ County Public Health
☒ County Social Services
☐ Foster Care Agencies
☒ Law Enforcement
☒ Court
☒ Probation Department
☐ Education
☒ Recovery support service providers (including recovery residences)
☐ Health Information technology stakeholders
☒ Other (specify) Public Defender, Criminal Justice Council

2. ***How was community input collected?***

☒ Community meetings
☒ County advisory groups
☐ Focus groups
☒ Other method(s) (explain briefly): Online survey via SurveyMonkey

3. ***Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.***

☐ Monthly
☐ Bi-monthly
☐ Quarterly
☒ Other/s, specify: about bi-monthly through 2016 and quarterly thereafter

Review Note: One box must be checked.

4. ***Prior to any meetings to discuss the development of this implementation plan, did representatives from SUD, Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?***

☒ SUD, MH, and Physical Health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

☐ There were no regular meetings previously, but they will occur during implementation.

☐ There were no regular meetings previously, and none are anticipated.

5. ***What services will be available to DMC-ODS clients under this County plan?***

☒ Withdrawal Management (minimum one level)
☒ Residential Services (minimum one level)
☒ Intensive Outpatient
☒ Outpatient
☒ Opioid (Narcotic) Treatment Programs
☒ Recovery Services
☒ Case Management
☒ Physician Consultation

How will these required services be provided?

REQUIRED

☐ All county operated
☒ Some county and some contracted
☐ All contracted.

OPTIONAL

☒ Additional Medication-Assisted Treatment
☐ Partial Hospitalization
☒ Recovery Residences
☐ Other (specify) _____

6. ***Has the county established a toll-free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?***

☒ Yes (required)
☐ No. Plan to establish by: _____

<u>Review Note</u>: If the county is establishing a number, please note the date that it will be established and operational.

7. ***The County will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.***

☒ Yes (required)
☐ No

8. ***The County will comply with all quarterly reporting requirements as contained in the STCs.***

☒ Yes (required)
☐ No

9. ***Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:***

1. ***Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment***
2. ***Existence of a 24/7 telephone access line with prevalent non-English language(s)***
3. ***Access to DMC-ODS services with translation services in the prevalent non-English language(s)***
4. ***Number, percentage of denied and time period of authorization requests approved or denied***

☒ Yes (required)
☐ No

PART II
PLAN DESCRIPTION

Narrative Description

1. COLLABORATIVE PROCESS

Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

Review Note: Stakeholder engagement is required in the development of the implementation plan.

The Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) developed a draft of the implementation plan based on what is most needed to advance care for individuals with substance use disorders (SUD), and made it available on the website with distribution by email to contracted providers and other key stakeholders (e.g., County agencies, County Medi-Cal managed care health plans). DPH-SAPC proceeded with conducting a series of stakeholder engagement meetings to ensure adequate opportunities for the public to provide feedback on the draft implementation plan and how it will ultimately be operationalized.

The initial kickoff meeting on August 13, 2015 presented key features of California's DMC-ODS Waiver, the County draft implementation plan, and the process for eliciting stakeholders' feedback. This initial meeting was followed by nine regional meetings conducted between August 19 and September 9, 2015 at locations throughout Los Angeles County that provided a review of the plan and produced feedback on each major section of the plan (Table 1).

Table 1: Regional Stakeholder Meetings

SPA	SD	CITY	FACILITY	DATE
1	5	Lancaster	High Desert Medical Center	August 24, 2015
2	3	Lake View Terrace	Phoenix Houses of Los Angeles	August 31, 2015
3	5	Arcadia	Arcadia Park	September 1, 2015
4	1	Los Angeles	Eagle Rock Library	September 8, 2015
5	4	Marina del Rey	Burton W. Chace Park	September 3, 2015
6	2	Los Angeles	MLK Community Engagement Center	August 19, 2015
				September 9, 2015
7	1	Commerce	Department of Health Services	August 20, 2015
8	2	Gardena	Behavioral Health Services	August 27, 2015
Legend: (SPA) Service Planning Area, (SD) Supervisorial District				

To ensure feedback from County agencies, health plans, and other organizational partners, DPH-SAPC conducted an invitational briefing and feedback session on August 26, 2015 that included representatives from the following entities:

- County Agencies:
  - Department of Children and Family Services (DCFS)
  - Department of Health Services (DHS)
  - Department of Mental Health (DMH)
  - DPH, Office of Strategic Planning
  - DPH, Children's Medical Services
  - Department of Public Social Services (DPSS)
  - District Attorney's Office
  - Probation Department
  - Public Defender's Office
  - Sheriff's Department
- Health Plans:
  - Health Net
  - L.A. Care Health Plan
- Other Entities:
  - California Community Foundation
  - Countywide Criminal Justice Coordination Committee (CCJCC)

An online survey was also developed that allowed stakeholders to provide detailed written feedback about each major section of the plan. Information from the online survey and the regional meetings was compiled and distributed via email to all SUD network contractors and meeting participants, and the implementation plan was updated based on feedback where appropriate. On December 17, 2015, DPH-SAPC held a system-wide meeting to report the results of its stakeholder engagement for the first phase of the feedback process and provided an overview of the major themes, as well as key system transformation efforts that will occur in the next one to three years. Stakeholders could attend in-person or via a real-time webinar. Overall, 88 percent of current SUD treatment providers participated in the stakeholder process held between August and December 2015, in addition to other County partners and interested parties (Table 2):

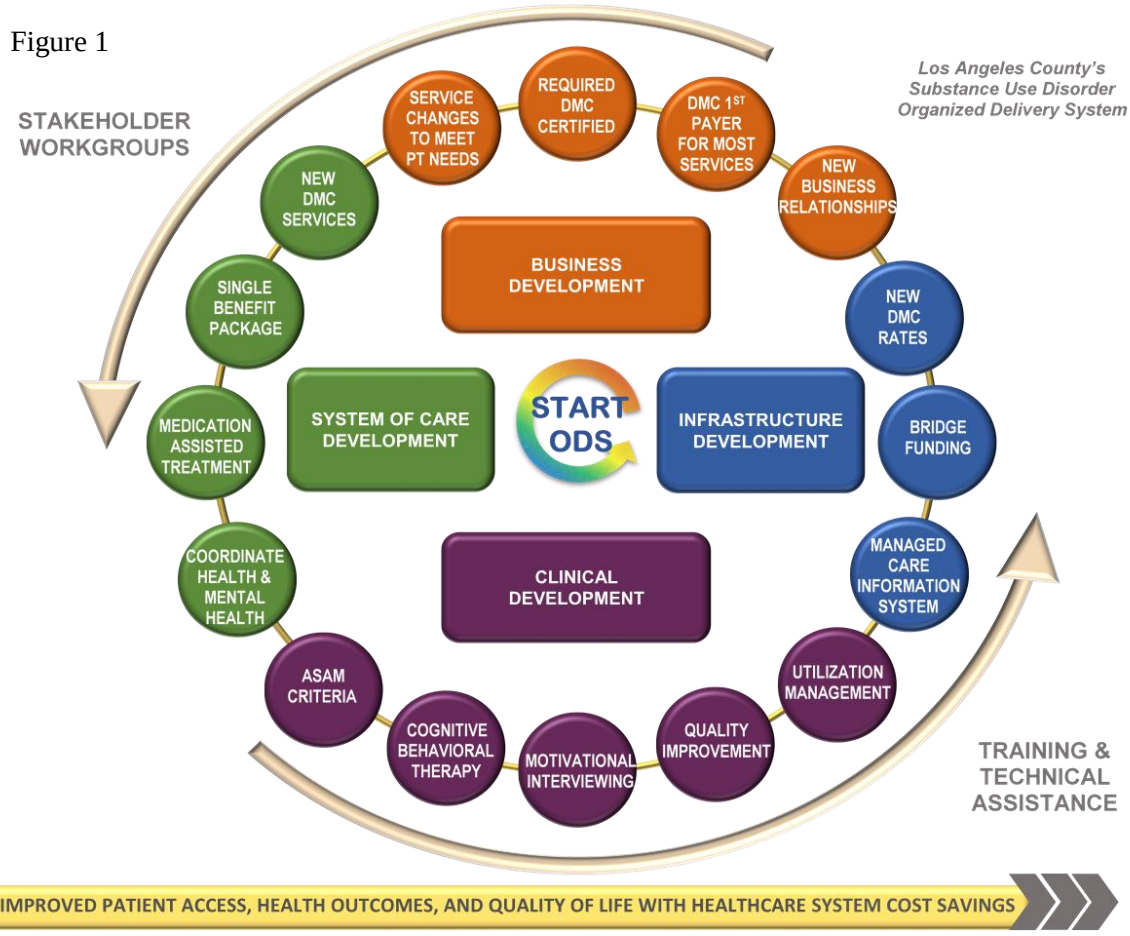
Table 2: Stakeholder Attendance

FEEDBACK TYPE	INDIVIDUALS	AGENCIES
Kick-Off Meeting	98	61
Regional Meetings	107	47
County/Health Plan Meeting	34	13
Online Survey (Complete)	65	60
Online Survey (Incomplete)	25	21
Results Meeting (In-Person)	107	70
Results Meeting (Webinar)	114*	87

* Represents the number of logins only so participation is underrepresented when sharing a viewing station

Submission of the DMC-ODS implementation plan will be the first step in the *System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorders Organized Delivery System* (START-ODS) and initiation of the operational plan to improve clinical care and outcomes. Efforts will occur in four major categories: business development, infrastructure development, clinical development, and system of care development. Stakeholder engagement workgroups, and technical assistance and training, will be central to ensuring development of an effective service system design and the ability to improve patient access, health outcomes, and quality of life with cost savings to the healthcare system overall due to greater investment in quality SUD services (Figure 1).

Figure 1



DPH-SAPC will convene the following anticipated stakeholder engagement workgroups now that the implementation plan has been submitted and these meetings will occur throughout the waiver period, as needed, in order to ensure the system of care is developed, enhanced, and maintained in a manner that supports quality care and improved patient outcomes, and that appropriately incorporates the expertise and perspective of stakeholders to establish a sustainable and effective network of providers.

- *System of Care Development*
  - Youth/Young Adult Services
  - Adult Services
  - Integration of Care

- *Clinical Development*
  - Quality Improvement
  - Utilization Management
- *Business and Infrastructure Development*
  - System Operations
    - Financing
    - Contracts
    - Information Technology
  - System Innovations and Network Capacity Building

These workgroups will be comprised of representatives from various agencies/groups including but not limited to the SUD provider network, the Commission on Alcohol and Other Drugs (County advisory body appointed by the Board of Supervisors), County entities/departments (CCJCC, DCFS, DMH, DHS, DPH, DPSS, Probation, Sheriff's Department, unions), managed care plans (Health Net, L.A. Care), consumer advocacy groups, education, and other interested community members. Information gathered from the previous regional meetings and the online survey will also be used to inform this process, including development of the standards of practice and overall system design. An email listserv was also developed to ensure that the entire SUD provider network, as well as other interested stakeholders, could stay informed about this process even when sending representatives to workgroup meetings is not feasible.

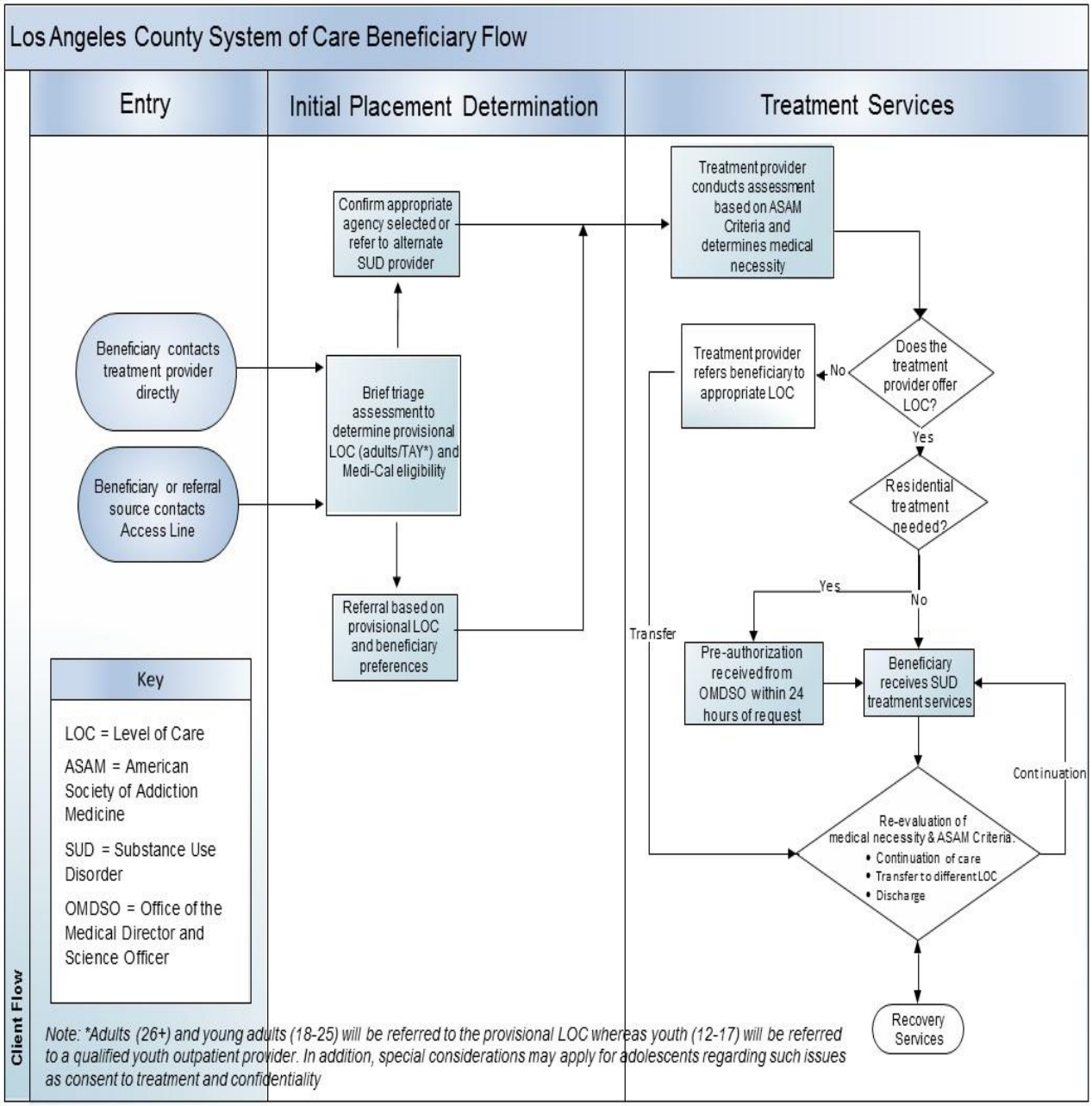
2. PATIENT FLOW

Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, and transitions to another level of care). Describe what entity or entities will conduct ASAM Criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care. Also describe if there will be timelines established for the movement between one level of care to another.

Review Note: A flow chart may be included.

DPH-SAPC operates two systems of care for SUD treatment services: one for adults (18 years of age and older) and one for youth (under 18 years of age). Young adults (18 through 25 years of age) are currently served primarily in the adult system of care, however, to better ensure delivery of developmentally appropriate services, the County intends to expand programs that target this specific age group in year three of the Waiver. Services are delivered through contracts with community-based State-certified and/or licensed SUD treatment programs, and the County-operated Antelope Valley Rehabilitation Centers (AVRC), an outpatient and residential treatment facility for adults. Referrals are accepted from all sources, including County Medi-Cal managed care health plans, other County departments, criminal justice and juvenile justice agencies, child dependency system, community-based human service agencies, employers, schools, families, and self. Services available include the entire range of services contained in the youth and adult benefit packages (Attachment 1). Beneficiaries move through the system of care via the Beneficiary Access Line and the SUD provider network (Figure 2).

Figure 2



There is no "wrong door" to enter SUD services. All individuals seeking admission to SUD services can access them by contacting the toll-free Beneficiary Access Line (see description below) or by contacting any contracted-SUD network provider. At that time, the individual will participate in a brief triage assessment, conducted by at minimum a registered counselor with the required experience and as permitted by DPH-SAPC, to determine the provisional level of care (LOC) based on the American Society of Addiction Medicine (ASAM) Criteria and Medi-Cal eligibility status. Adults and young adults will be referred to the provisional LOC for further assessment whereas youth will be referred to a qualified youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate higher LOC as necessary.

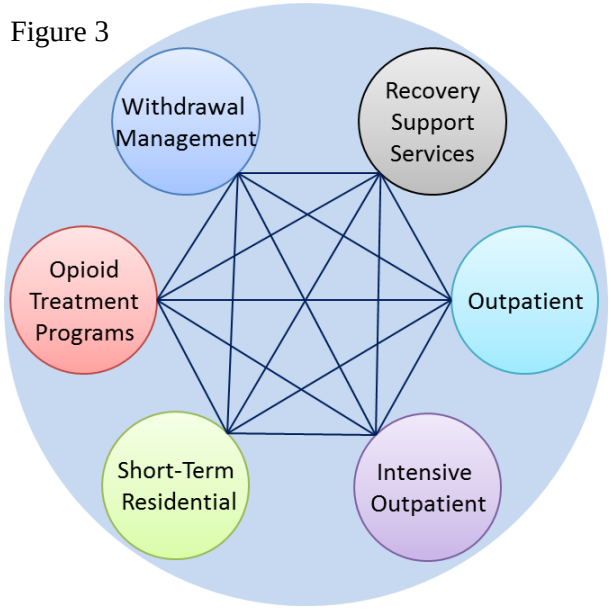
If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options in accordance with County requirements to ensure an individual is offered services at the optimal LOC, and assist the individual in connecting with the selected agency; the individual may elect, however, to remain with the initial provider after receiving other referral options (e.g., the individual prefers to receive intensive outpatient services despite qualifying for residential services). All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services.

In either case, individuals who need SUD care must be scheduled for an appointment within three business days and receive a face-to-face appointment within 15 business days from the brief triage assessment date; beginning in July 2017 the face-to-face target will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018. This approach will allow DPH-SAPC to expand its residential capacity and phase in tighter timeframes for first face-to-face appointment for residential services. If the recommended LOC is unavailable, the individual will be referred to the next highest, appropriate LOC for assessment and interim services. At this appointment, the provider will conduct a more intensive biopsychosocial clinical assessment using a standardized tool based on the ASAM Criteria to establish and/or confirm the appropriate LOC placement, and initiate services as indicated. Both the brief triage assessment and the more comprehensive ASAM assessment will be performed by registered counselors with the required experience and as permitted by DPH-SAPC, certified counselors or Licensed Practitioner of the Healing Arts (LPHA). Given that the brief triage assessment yields only a provisional LOC determination, initial medical necessity will need to be determined at the provider site and an LPHA will need to sign off on the more comprehensive ASAM assessment, if it is performed by a registered or certified counselor. If the initial brief triage assessment and the full ASAM-based assessment to determine medical necessity and the appropriate LOC involve different providers, the initial provider will be responsible for ensuring a "warm hand-off" to support completion of the assessment appointment and enrollment in services.

When the brief triage assessment and/or the full ASAM assessment indicates that placement in a residential treatment program (ASAM level 3.1, 3.3, 3.5) is needed, the selected provider will submit a pre-authorization request to DPH-SAPC's Office of the Medical Director and Science Officer, which will conduct a pre-authorization review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a County-operated or community-based residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss (e.g., not billable to other state and federal sources) whereas authorization approvals will be retroactively reimbursed to the date of admission. Pre-authorization by the County is not required for admission into other ASAM LOCs, though it will be required for Medication-Assisted Treatment for those under age 18.

Once admitted into services, an individualized treatment plan will be developed by at minimum a registered counselor with the required experience and as permitted by DPH-SAPC and signed by an LPHA. At a minimum, treatment plan *reviews* for youth and adults are required at least every 30 days and treatment plan *updates* are required at least every 90 days in outpatient, intensive outpatient, and opioid treatment program settings. For residential settings, treatment plan *updates* are required at least every 30 days, with treatment plan *reviews* occurring as needed and appropriate. Treatment plans in more intensive LOCs, such as residential settings, should be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. As patients advance through treatment, the corresponding treatment plan should be reviewed and adjusted accordingly based on stability and the likelihood of rapid changes in patient condition. If a patient's condition does not show improvement at a given LOC or with a particular intervention, then a review, abbreviated assessment, and treatment plan modification should be made in order to improve therapeutic outcomes. Changing the LOC or intervention should be based on a reassessment and modification of the treatment plan in order to achieve an improved therapeutic response.

Figure 3



Should it be determined that the individual requires a change in LOC during the course of treatment, the current treatment provider will assist the individual in transferring to the appropriate LOC within the provider organization or by coordinating a referral to another treatment program with assistance from the Beneficiary Access Line as needed. An individual can move between LOCs, or in some cases be in services concurrently (e.g., residential and opioid treatment programs), as clinically appropriate (Figure 3). Transitions between LOCs will be documented as required by DPH-SAPC to better ensure successful connections with the new service location/provider, including the facilitation of warm hand-offs whenever possible.

Discharge planning between LOCs, during treatment exit, and between systems of care (physical health, mental health, and substance use systems) is an integral component of the treatment process and begins at the time of admission. Processes to prepare the individual for return or reentry into the community include linkages to essential supportive services such as education, employment training, employment, housing, benefit enrollment, and other human services as indicated at assessment and during the treatment process.

Individuals who completed their episode of treatment, or prematurely exit the SUD system of care, are eligible to receive recovery support services from the last treatment provider of care or another provider if preferred, which will reengage the individual into treatment if needed.

Case-management and care coordination will be an essential component to ensuring that individuals successfully engage in the initial treatment episode, receive necessary services, and transition through care as clinically appropriate. These services will assist patients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative or other community services, and will be provided by registered counselors with the required experience and as permitted by DPH-SAPC, certified counselors, and LPHAs. The initial treating provider will be responsible for providing case management services and communicating with the next provider along the continuum of care to ensure smooth transitions between LOCs. Once an individual has successfully admitted for services at the next LOC, the new treating provider (if a different agency) will assume case-management responsibilities. DPH-SAPC is also in the process of determining its role in providing case management services, as the administrative oversight of its provider network, and is determining how best to coordinate case management with the managed-care health plans, and DHS and/or DMH for those receiving services for co-occurring conditions. A model of case management that is tiered based on risk and/or the level of patient service need (e.g., SUD only versus co-occurring conditions) is being considered and procedures will be finalized before service delivery.

In each case, all beneficiaries, where medical necessity for SUD services has been determined, will have access to case-management and/or care coordination services to assist with admission into SUD services, transitioning from one LOC to another, and navigating the mental health, physical health and social service systems. Treatment provider staff will monitor and track beneficiary progress, coordinate care, and provide linkages with community support services, as well as coordinate referrals to other LOCs. They will also communicate with network providers as beneficiaries move between LOCs and into post-discharge recovery services to support successful transition(s). The County will utilize a risk stratification tool at the Beneficiary Access Line and at provider sites to identify individuals at-risk for high utilization and care transition complications. DPH-SAPC will explore the feasibility of directly providing or subcontracting additional case-management support to individuals stratified into this high-risk group during year two of the Waiver. Under this model, County case management staff would coordinate with case managers at relevant SUD provider sites and in other systems (e.g., health plans, physical and mental health) to ensure that there is a primary case manager responsible for coordinating an individual's care. In some instances, the primary case manager may be the County case management staff at SAPC or a subcontractor. In other instances the primary case manager may be based from a local health plan, DHS or DMH. In this way, case management for this high-risk population would ensure that appropriate LOCs are tailored to individual need within both the SUD and other health systems. In the interim, DPH-SAPC will continue to collaborate with the health plans, DHS and DMH to ensure effective coordination of services.

3. BENEFICIARY ACCESS LINE

For the beneficiary toll-free access number, what data will be collected (i.e., measure the number of calls, waiting times, and call abandonment)?

The Beneficiary Access Line will be operational 24-hours per day, including on weekends and holidays, and will be answered by a live-person at all times. Callers with emergency or urgent needs will be directed to contact 911 or to proceed to the nearest hospital emergency department. Services will be offered in English and Spanish, and a translation service will be immediately available for all other threshold languages; there will also be the ability to communicate with individuals with hearing impairments (e.g., Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD)).

At a minimum, registered counselors, with the required experience and as permitted by DPH-SAPC, will conduct screening interviews with callers or those seeking services in-person using the standardized adolescent or adult brief triage assessment based on the ASAM Criteria, make a provisional LOC determination, identify Medi-Cal eligibility, and schedule an assessment/admission appointment with a network provider. DPH-SAPC is developing an automated system (target completion date July 2017) to identify available treatment slots/beds in the community and schedule assessment/admission appointments at a location that provides the provisional LOC recommended by the brief triage assessment and aligns with other patient preferences/needs. This system should streamline the patient's entry into the system of care, and better ensure receipt of culturally, linguistically, and developmentally appropriate services.

Appointments will be scheduled with the selected provider while the caller is on the line whenever possible, but no later than three business days, and tracked according to DPH-SAPC requirements. A reminder and follow-up process will be established in accordance with "warm hand-off" procedures to better ensure that beneficiaries attend the assessment/admission appointment. In these instances, the initial provider will be responsible for actively transitioning a patient to the subsequent provider, as consistent with the "warm hand-off" model, and will be responsible for following up with the patient to ensure that he/she attended the assessment/ admission appointment. Once this has been confirmed, the responsibility for the patient is transitioned to the subsequent provider. All access line procedures will be conducted with the individual as a full participant in the decision-making process, including offering referral options that align with geographic, service hour availability, cultural, and other preferences.

The following information will be collected by the Beneficiary Access Line for continuous quality improvement purposes:

- Number of calls received by day and time blocks;
- Rate of call abandonment;
- Rate of unanswered calls;
- Number of brief triage assessments conducted;
- Number of referrals to treatment by LOC;
- Number of days from initial call/contact to assessment/admission appointment;

- Number of individuals who attended assessment/admission appointment;
- Analysis of wait time to treatment enrollment;
- Demographic characteristics of callers (age, gender, ethnicity/race, primary language if non-English speaking, ZIP Code of residence); and
- Insurance status by health plan (e.g., L.A. Care, Health Net) and funding source (e.g., DMC).

SAPC is in negotiations with one of the Los Angeles County Medi-Cal Managed Care Plans to operate the Beneficiary Access Line using their existing 24-hour member services line. This line would be operational by the launch of Waiver services. Individuals could also continue to access services directly at SAPC contracted SUD treatments sites.

4. TREATMENT SERVICES

Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding ASAM level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

The County will implement an initial benefit package of SUD services within the initial 12 months of execution of the new State and County contract (Table 3, Attachment 1). For youth this will include ASAM LOCs 1, 2.1, 3.1 and 3.5; for adults this will include ASAM LOCs 1, 2.1, 3.1, 3.3, 3.5, 1-WM, 3.2-WM, and 1-OTP as well as medication-assisted treatment. Medication-assisted treatment will be available to youth on a case-by-case basis depending on clinical need, and case-management/care coordination, recovery support, and physician consultation services will be available to all beneficiaries served within the DPH-SAPC system of care. By year three, ASAM LOC 2-WM will be added to the benefit package for adults.

Several LOCs are funded outside of the SUD system of care (ASAM 0.5, 2.5, 3.7 and 4.0); however, DPH-SAPC and its network of providers will coordinate referrals where needed to better ensure delivery of services that best match the beneficiaries' level of need. A Memorandum of Understanding with the Medi-Cal Managed Care plans in Los Angeles County (L.A. Care and Health Net) will delineate and facilitate this cross-system referral process. Beneficiaries who are transitioning from ASAM levels 3.7 and 4.0 will be referred to the Beneficiary Access Line to initiate entry into the SUD system of care. As is the case for all individuals who contact the Beneficiary Access Line, those transitioning from ASAM levels 3.7 and 4.0 will be stratified according to risk (see Section 2, Patient Flow) and referred to a provisional LOC as determined by the brief triage assessment. Given the crucial transition

period between an inpatient hospital and community-based setting, every effort will be made to ensure a "warm hand-off" to better enable these beneficiaries to attend the assessment/admission appointment. The transition into ASAM levels 3.7 and 4.0 is equally critical and will be facilitated by the Beneficiary Access line if it is determined that an individual requires that LOC. SAPC will actively engage hospitals in Los Angeles County and their provider associations to provide information and materials describing the resources of the expanded SUD benefits package and the delivery system transformation. Outreach activities will emphasize the role of the Beneficiary Access Line in facilitating referrals between inpatient LOCs and emergency departments and SAPC's delivery system.

DPH-SAPC-Funded LOC Descriptions

Outpatient Services (ASAM Level 1.0): Services are provided by a DHCS-certified outpatient facility and consist of counseling for up to nine hours per week for adults and up to six hours per week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. Medication-Assisted Treatment (MAT) will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC. *Note: As described in Section 18, "Additional Medication-Assisted Treatment," all DPH-SAPC network patients will have access to MAT via the MAT hubs. Unlike with treatment slots and residential bed capacity, MAT capacity at each LOC is not a fixed number and varies depending on caseload and the number of prescribers at the MAT hubs. Efforts will be made to increase appropriate referrals for MAT at all LOCs, and fully utilize and where needed expand, current capacity (see Figure 10).*

Intensive Outpatient Services (ASAM Level 2.0): Services are provided by a DHCS certified intensive outpatient facility and include structured programming provided to beneficiaries for a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, safeguarding medications, transportation services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC. *Note: See additional information on MAT capacity under "Outpatient Services" above.*

Low Intensity Residential Services (ASAM Level 3.1): Services are provided by a California Department of Social Services (CDSS) licensed group home facility for youth or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.1 designation, and include 24-hour care with at least five hours of clinical services per week. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related

SUD condition that are receiving services at this LOC. *Note: See additional information on MAT capacity under "Outpatient Services" above.*

High Intensity Residential Services – Population Specific (ASAM Level 3.3): Services are provided by a DHCS licensed residential facility for adults with a DHCS ASAM Level 3.3 designation, and include 24-hour care for adults who are unable to successfully function in a more active milieu. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. This LOC is not available for youth. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

High Intensity Residential Services – Non-Population Specific (ASAM Level 3.5): Services are provided by a CDSS licensed group home facility for youth with a DHCS residential license or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.5 designation, and include 24-hour care for those who are able to successfully function in a more active milieu. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – No Extended On-Site Monitoring (ASAM Level 1-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with mild withdrawal who require daily or less than daily supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – Extended On-Site Monitoring (ASAM Level 2-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/ licensed prescriber, and are for individuals with moderate withdrawal who require all day support and supervision, but who have a supportive family or living situation at night. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Residential Withdrawal Management – Clinically Managed (ASAM Level 3.2-WM): Services are provided by a DHCS licensed residential facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with moderate withdrawal who require 24-hour support and supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Table 3: SUD Benefit Package and Timeline

Level Of Care (LOC)/Service	ASAM Level	DMC-ODS LOC By Launch		DMC-ODS LOC End Year Three	
		Youth	Adult	Youth	Adult
Early Intervention	0.5	No	No	No	No
Outpatient	1	Yes	Yes	-	-
Intensive Outpatient	2.1	Yes	Yes	-	-
Partial Hospitalization	2.5	No	No	No	No
Low Intensity Residential	3.1	Yes	Yes	-	-
High Intensity Residential Population Specific	3.3	N/A	Yes	N/A	-
High Intensity Residential Non-Population Specific	3.5	Yes	Yes	-	-
Intensive Inpatient Services Medically Monitored	3.7	No	No	No	No
Intensive Inpatient Services Medically Managed	4.0	No	No	No	No
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	N/A	Yes	N/A	-
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	N/A	No	N/A	Yes
Residential Withdrawal Management Clinically Managed	3.2-WM	N/A	Yes	N/A	-
Inpatient Withdrawal Management Clinically Managed	3.7-WM	No	No	No	No
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	No	No	No	No
Opioid Treatment Program	1-OTP	N/A	Yes	N/A	-
Addiction Medications With Concurrent Outpatient/Residential		N/A	Yes	N/A	-
Case Management/Care Coordination		Yes	Yes	-	-
Recovery Support Post Discharge		Yes	Yes	-	-

Opioid Treatment Program (ASAM Level 1-OTP): Services are provided by a DHCS licensed Narcotic Treatment Program (NTP) facility with a physician/licensed prescriber, and are for individuals who require daily or several times weekly opioid agonist medications and counseling to address severe opioid use disorder. Services include: intake, treatment planning, group counseling, individual counseling, patient education, crisis intervention services, collateral services, medication services, medical psychotherapy, and discharge planning services.

Specifically, the choice of MAT (e.g., methadone vs. buprenorphine) will be based on a comprehensive clinical assessment by the prescriber at the OTP site and must consider the varied biopsychosocial needs and preferences of each individual case. The County will continue to encourage, through trainings and physician engagement and consultation, diversification of MAT in the OTP setting. The County will also explore having OTPs serve as MAT hubs (see Section 18, Additional Medication-Assisted Treatment). This LOC is generally not available for youth except with DPH-SAPC prior authorization.

Note: For youth, the benefit package is established as a developmentally-appropriate set of services. Not all LOCs or types of services available to adults and young adults are included in the benefit package for youth, such as Withdrawal Management and Medication-Assisted Treatment because these services are generally not approved or appropriate for this population. However, on a case-by-case basis as determined as medically necessary with prior authorization by DPH-SAPC, such services will be made available to youth.

DPH-SAPC Other Service Descriptions

Recovery Support: These services are available to all patients who enter the SUD treatment system, and individuals released from incarceration who have completed a course of in-custody treatment services that align with medical necessity and the ASAM Criteria, and should be available for a minimum of six months. The last treatment provider of care will serve as the default provider unless needed service(s) are not offered or the patient prefers a change in provider. The recovery support provider will contact the patient within two business days after discharge from his/her last treatment service to ensure that the individual is receiving necessary support to increase their likelihood of recovery success. At least three documented attempts to engage patients will be required to demonstrate efforts to engage an individual in services prior to presuming that they are lost to follow-up. These individuals will also be able to re-engage in recovery support services at any time if experiencing triggers or if in need of additional support. The recovery support provider will also be responsible for reengaging the individual in treatment at a later time, if needed. Services include: individual counseling, group counseling, recovery monitoring, and peer-to-peer substance abuse assistance as well as linkages to schools/educational programs, job skills development, support groups, family support, and other ancillary services.

Case-Management/Care Coordination: These services are available to all patients who enter the SUD treatment system, and are available throughout the treatment episode and may be continued during recovery support as allowed by DPH-SAPC. Services include: regular assessment and reassessment to determine need for continued services at the appropriate level, transitions in LOCs, treatment plan development and updates, coordination of referrals (including connections with and transportation to physical and mental health services), monitoring progress in services, and patient advocacy. The County will utilize a risk stratification tool at the Beneficiary Access Line and at provider sites to identify individuals at-risk for high utilization and care transition complications. DPH-SAPC will explore the feasibility of directly providing or subcontracting additional case-management support to individuals stratified into this high-risk group during year two of the Waiver. Under this model, County case management staff would coordinate with case managers at relevant SUD provider sites and in other systems (e.g., health plans, physical and mental health) to ensure that there is a primary case manager responsible for coordinating an

individual's care. The lead case manager (health plan, SAPC, DMH) would be determined based on the individual's primary service need, and ensure that appropriate LOC are tailored to individual need within both the SUD and other health systems. In the interim, DPH-SAPC will continue to collaborate with the health plans, DHS and DMH to ensure effective coordination of services.

Recovery Residences: These services are currently available to perinatal and AB 109 patients on a limited basis. The degree to which this can be further expanded, especially to facilitate step-down from residential services, will be determined during year one of implementation. This process includes ensuring adequate quality standards and determining what facility types would be expanded (e.g., National Association of Recovery Residences, Sober Living Network), what criteria would be used to determine patient eligibility, and the degree to which DPH-SAPC would provide funding for specific patients or simply establish a referral network based on determined facility standards. Services would not be provided on-site at recovery residences, but any resident receiving rent support would need to participate in outpatient, intensive outpatient, case-management, and/or recovery support services, as necessary. The cost for recovery residences, including room and board, would be funded by non-DMC resources such as the Substance Abuse Prevention and Treatment Block Grant and realignment funds.

Physician Consultation: This includes consultations for DMC physicians with addiction-trained physicians to ensure that SUD providers have access to non-emergency clinical and medical information that can be used to improve care and services for individuals with SUDs. These consultations will occur either telephonically or electronically, via the DPH-SAPC website or managed care information system, and will not occur in real-time. Question topics may include medication-assisted treatments, dosage recommendations, the management of unusual or difficult cases, and LOC recommendations. This service will either be directly operated by DPH-SAPC or subcontracted.

Additional Medication Assisted Treatment: See Section 19 for more information.

Expansion of Services and Barriers to Implementation

A system transformation this extensive will require substantial investment in the clinical, business, and technological infrastructure at both the County- and provider-level, to ensure success of the DMC-ODS pilot and the ability to demonstrate desired outcomes. This infrastructure includes the quality and care coordination standards (e.g., use of the ASAM Criteria, evidence-based practices) that will help improve patient care. Meeting these requirements also comes with additional costs such as hiring and maintaining a well-qualified workforce, providing on-going training and ensuring fidelity to evidence-based practice models and other standards. Therefore, the reimbursement rates must adequately account for the associated costs to build this improved system of care while also moving it into closer alignment with the mental and physical health systems in accordance with parity. It will also be essential to ensure adequate availability of services, which necessitates expanding the number of providers/service sites (especially residential service sites that also include licensing and zoning requirements) and certifying new agencies and sites in a timely manner. Ensuring adequate reimbursement rates during the negotiation process between the County and State will be critical,

as the enhancements and expansion of services outlined within the DMC-ODS pilot will require concomitant financial support.

Cross-County Coordination

In the event that a Medi-Cal beneficiary from another county seeks SUD services that are determined medically necessary but who is not able to receive services directly from that County, DPH-SAPC may provide the services based on those benefits offered by the County of residence and if provided would seek reimbursement from the County of residence at Los Angeles County's approved rate. The cost for services provided to out-of-county residents would be included in the County of residence's certified public expenditure. Los Angeles County would obtain the revenue (both the federal share of cost and the local match) from the County of residence.

5. COORDINATION WITH MENTAL HEALTH

How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

A current Memorandum of Understanding (MOU) between DPH-SAPC and DMH defines the coordination of mental health and SUD services for Medi-Cal beneficiaries. DPH-SAPC and DMH work closely together to ensure that services are being provided adequately and appropriately for beneficiaries with co-occurring conditions, and will further discuss how to define, improve and ensure care coordination among the health plans, DMH and DPH-SAPC for individuals with physical, mental health, and/or SUD treatment needs. Increasingly, DMH has added DPH-SAPC network providers to its contracted specialty mental health provider network to support an integrated approach to services.

The two County Medi-Cal managed care health plans (Health Net and L.A. Care) are responsible for addressing the mental health services needs of its members with mild to moderate mental health conditions. DPH-SAPC coordinates care with the two County health plans for those with co-occurring SUD and mild to moderate mental health conditions. This relationship is established and defined through MOUs with the two County health plans. DPH-SAPC and the two County health plans are actively assisting the County-contracted SUD network providers to become credentialed by the health plans to provide services for mild to moderate mental health conditions as a means to implement integrated care for this population.

6. COORDINATION WITH PHYSICAL HEALTH

Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

In compliance with the DMC-ODS Standard Terms and Conditions, DPH-SAPC is establishing MOUs with the two County Medi-Cal managed care health plans (Health Net and L.A. Care) that define coordination of physical health and SUD services for Medi-Cal beneficiaries (Attachment 2).

DPH-SAPC has already established MOUs with the two County health plans, DHS, DMH, and DPSS for the County's participation in the Cal MediConnect demonstration project for dual Medicare and Medi-Cal beneficiaries. DPH-SAPC, DMH, and the two County health plans will use the care coordination infrastructure established for the Cal MediConnect project to build the DMC-ODS care coordination infrastructure.

The Behavioral Health Steering Committee and Program Administration Team will provide overall policy and programmatic leadership for the coordination of care across physical health, mental health, and SUD service systems. Meetings will be bi-monthly and include leadership from the health plans and County departments. Interdisciplinary care coordination teams comprised of clinical personnel from the health plans and County partners meet regularly to discuss care coordination for beneficiaries with multiple co-occurring conditions. Sharing of patient information is conducted with patient consent in accordance with all applicable patient confidentiality requirements to support decisions about care coordination involving the County-contracted SUD network providers, County health plan network providers, and DMH specialty mental health network providers. The County-contracted SUD provider network is already actively engaged in care coordination with mental health and physical health providers through the infrastructure established for the Cal MediConnect project as described above.

DPH-SAPC coordinates with the County Medi-Cal managed care health plans to ensure that beneficiaries have access to and receive SUD services through health plan network providers for services reimbursable by Medi-Cal but not included in the DMC-ODS benefits such as voluntary inpatient detoxification services in general acute hospitals (ASAM Levels 3.7-WM, 4-WM) and Screening, Brief Intervention and Referral to Treatment (SBIRT) services (ASAM Level 0.5) in primary care settings.

DPH-SAPC also has a well-established care coordination relationship with DHS, which provides physical health services for Medi-Cal beneficiaries under an agreement with L.A. Care, and also for the uninsured safety net population.

The expansion of SUD services available under the DMC-ODS implementation plan greatly improves access to SUD services for persons with co-occurring mental health and physical health conditions, particularly in terms of access to residential treatment services, which have historically been difficult to access for medically indigent individuals due to limited County, State and federal funding.

7. COORDINATION ASSISTANCE

The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- ***Comprehensive substance use, physical, and mental health screening;***
- ***Beneficiary engagement and participation in an integrated care program as needed;***
- ***Shared development of care plans by the beneficiary, caregivers and all providers;***
- ***Collaborative treatment planning with managed care;***
- ***Care coordination and effective communication among providers;***
- ***Navigation support for patients and caregivers; and***
- ***Facilitation and tracking of referrals between systems.***

The following challenges have been identified for effective provision of coordinated and integrated mental health, physical health, and SUD services for beneficiaries with multiple, co-occurring conditions:

- Patient Data-Sharing Between Systems – The current requirements of 42 Code of Federal Regulations (CFR) Part 2 make sharing of patient information between systems cumbersome. State advocacy to revise or waive these requirements for the Waiver demonstration would allow more effective and efficient care coordination practices.

  DPH-SAPC is presently an active participant in County efforts to establish an electronic managed care information system that would allow patient data exchange between physical health, mental health, and SUD service systems. DPH-SAPC is also engaged with DMH, DHS, and County health plans to establish a patient consent form that would be used by all partners to authorize exchange of patient information for the purposes of care coordination.

- Payment Reform – Current Medi-Cal payment systems for mental health, physical health, and SUD services are cumbersome, and discourage effective and efficient coordinated or integrated care approaches. The changes to permit same-day billing for Medi-Cal reimbursed services (physical, mental health, SUD) for counties participating in the waiver, as outlined in the DHCS' Information Notice 16-007, is a significant step to improving and supporting cross-system coordinated and integrated care and should be maintained. Payment and provider enrollment incentives for Medi-Cal providers with

coordinated and integrated care approaches to service delivery would further promote the adoption of such approaches as the standard for statewide service delivery.

DPH-SAPC is actively engaged with the County lobbyist, the advocacy efforts of provider associations and the County Behavioral Health Directors Association of California, and DHCS to enact federal, State, and County legislation and regulatory changes needed to advance coordinated and integrated care by removing barriers described above.

- Cross-System Workforce Development – The workforces in mental health, physical health and SUD service networks have limited expertise in identifying and addressing multiple co-occurring conditions through care coordination, with a cross-systems, integrated approach. Workforce training on best practices for patient screening, problem and risk identification, brief intervention for substance use problems, and patient engagement in SUD services are needed for the mental health and physical health workforces. Training in care coordination is needed by all three workforces.

  DPH-SAPC is actively engaged with DHS and DMH along with the County-designated Medi-Cal managed care health plans, and other stakeholder groups to implement cross-system workforce training on effectively working with persons with SUD among other multiple co-occurring conditions.

8. ACCESS

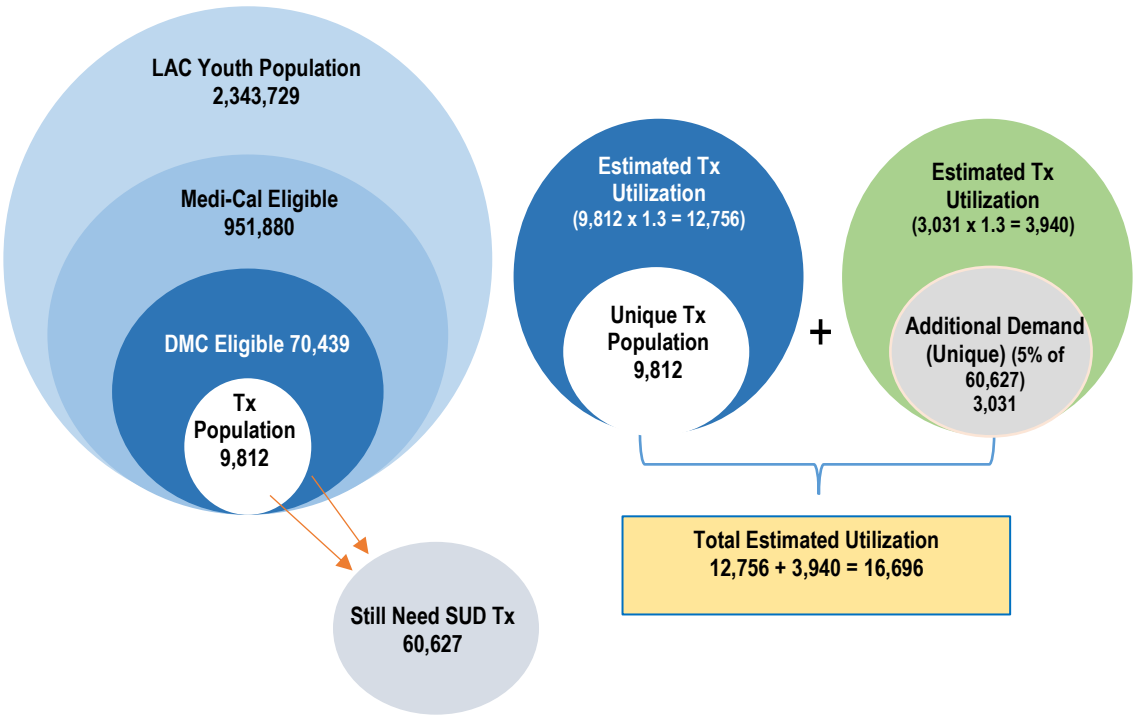
Describe how the county will ensure access to all service modalities. Describe the county's efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

- ***The anticipated number of Medi-Cal clients;***
- ***The expected utilization of services;***
- ***The numbers and types of providers required to furnish the contracted Medi-Cal services;***
- ***Hours of operation of providers;***
- ***Language capability for the county threshold languages;***
- ***Timeliness of first face-to-face visit, timeliness of services for urgent conditions, and access to afterhours care; and***
- ***The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.***

DPH-SAPC conducted an analysis to project utilization of SUD services given the expansion of Medi-Cal eligibles and LOCs reimbursable under DMC. Based on analysis of 2013 census data, approximately 2.8 million people are estimated to be at or below 138 percent of the federal poverty limit (FPL) and potentially eligible for Medi-Cal in Los Angeles County. Of those 2.8 million people, about 951,880 are estimated to be youth and 1.8 million are estimated to be adults. According to the National Survey on Drug Use and Health (NSDUH) data, the estimated prevalence of SUDs among adults in poverty is about 13 percent, and about 7.4 percent in youth. Using these prevalence rates, DPH-SAPC estimates that approximately 70,439 youth and 236,338 adults are DMC eligible, and thus may need DMC services, in Los Angeles County.

Averaging historical youth (12-17) utilization data over the last 10 years, the annual unique patients served amounted to 9,812 with an average of 1.1 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.1) or increased (medium – 1.3; high – 1.6) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission variables to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual youth patients served is 10,793 (low readmission estimate) to 20,549 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission variable 1.3), Los Angeles County anticipates total utilization of at least 16,696 duplicated youth served annually of which 63 percent (10,518) are expected to need outpatient, 27 percent (4,508) intensive outpatient, and 10 percent (1,670) residential; another 60,627 youth are expected to need but not seek SUD services (Figure 4).

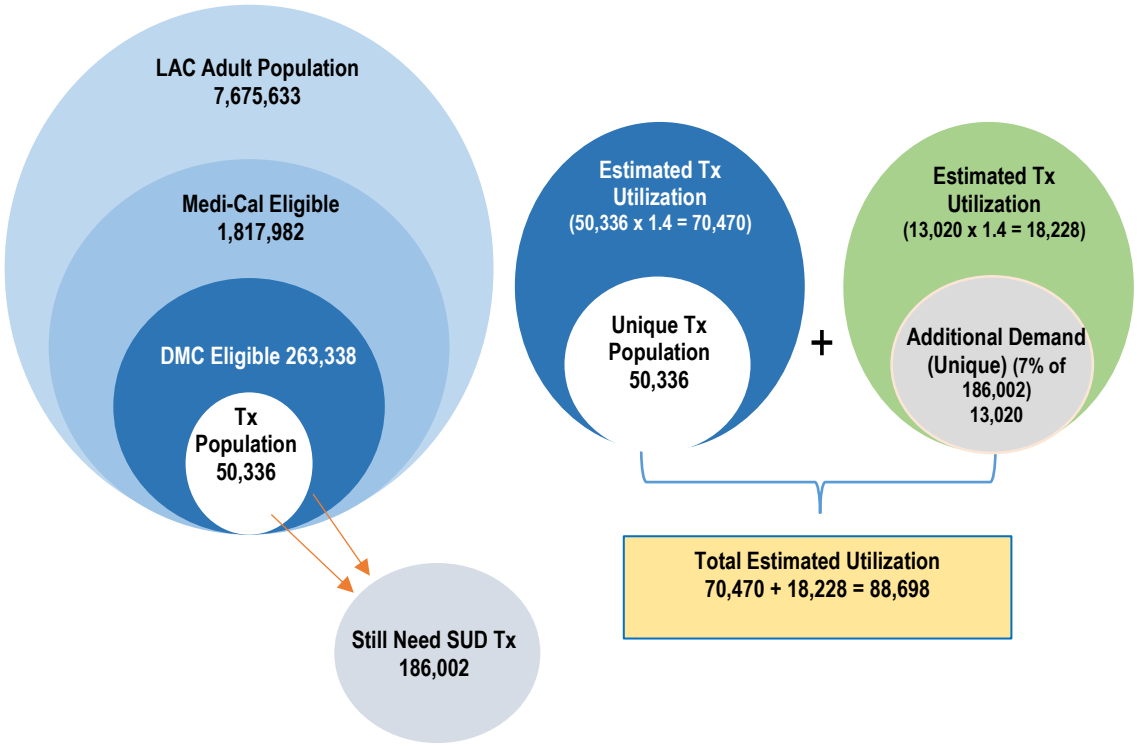
Figure 4: DMC-ODS Medium Utilization Estimation for Youth



Averaging historical adult utilization data over the last 10 years, the annual unique patients served amounted to 50,336 with an average of 1.2 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.2) or increased (medium – 1.4; high – 1.8) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission multipliers to estimate total

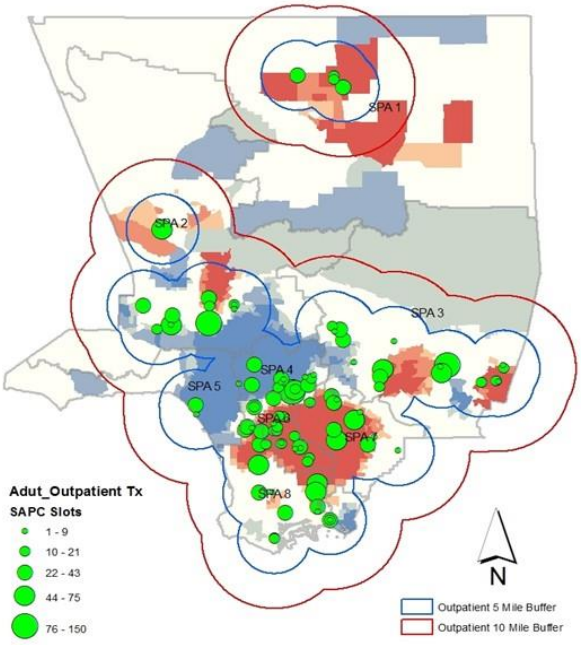
utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual patients served is 60,403 (low readmission estimate) to 114,041 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission multiplier 1.4), Los Angeles County anticipates total utilization of at least 88,698 duplicated adults served annually, with another 186,002 adults in need of SUD services (Figure 5). It is expected, however, that utilization may increase for both youth and adults as services become more accessible County-wide, individuals become aware of the SUD benefits, care coordination and case-management improves, and stigma declines.

Figure 5: DMC-ODS Medium Utilization Estimation for Adults



Using the medium utilization estimates described above and the provider survey on bed and slot capacity conducted by DPH-SAPC last year, there is a potential deficit in adult outpatient, intensive outpatient, residential, withdrawal management and opioid treatment programs services depending on how quickly new services are accessed and how quickly capacity is expanded (Figures 6, 7, 8, 9, 10). DPH-SAPC plans to conduct a similar analysis for youth utilization estimates (expected completion date June 2016) and will use both adult and youth utilization estimation analyses and other analyses (e.g., primary language hot spot analysis) to determine service gaps/needs. These data will inform a solicitation process to further improve access to care for beneficiaries by year two of the pilot, with continued expansion in year three as needed.

Figure 6: Adult Outpatient – Medium Utilization Estimate

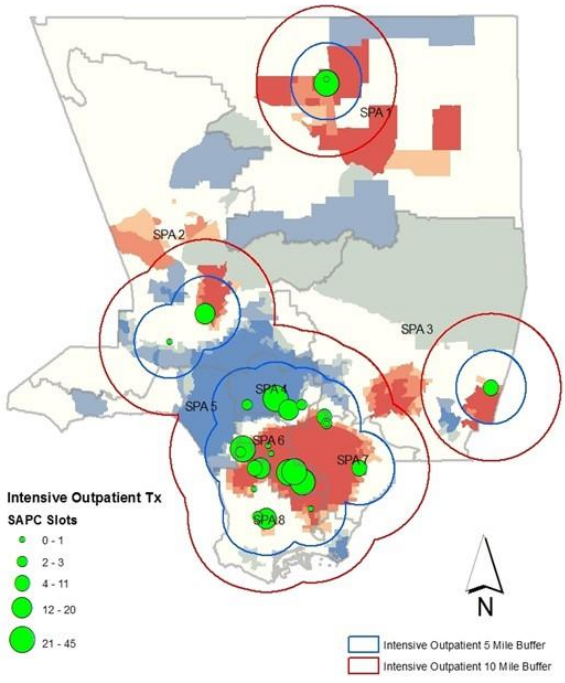


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	30,557
Estimated utilization	36,366 (41%)
Patients per slot per year	7*
Total slots needed	5,195
SAPC slot capacity	2,402
Additional slots needed	2,793
Number of Facilities	98

* Patients 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)

Figure 7: Adult Intensive Outpatient – Medium Utilization Estimate

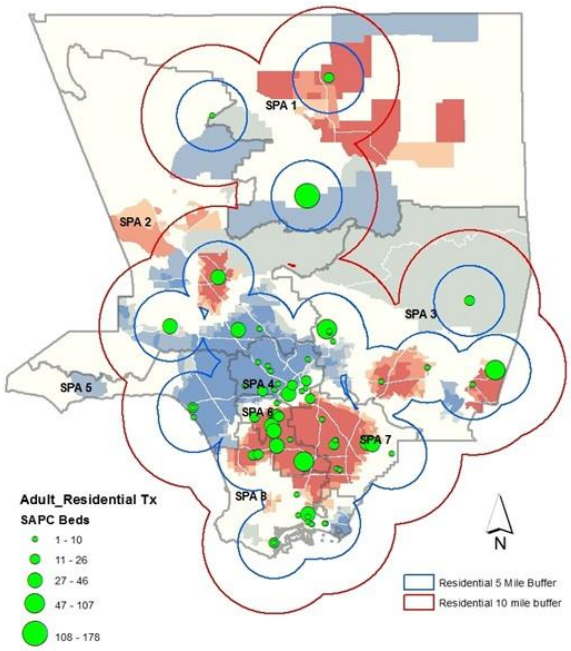


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	2,102
Estimated utilization	5,322 (6%)
Patients per slot per year	5*
Total slots needed	1,064
SAPC slot capacity	375
Additional slots needed	689
Number of Facilities	26

*Patients 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).

Figure 8: Adult Residential – Medium Utilization Estimate

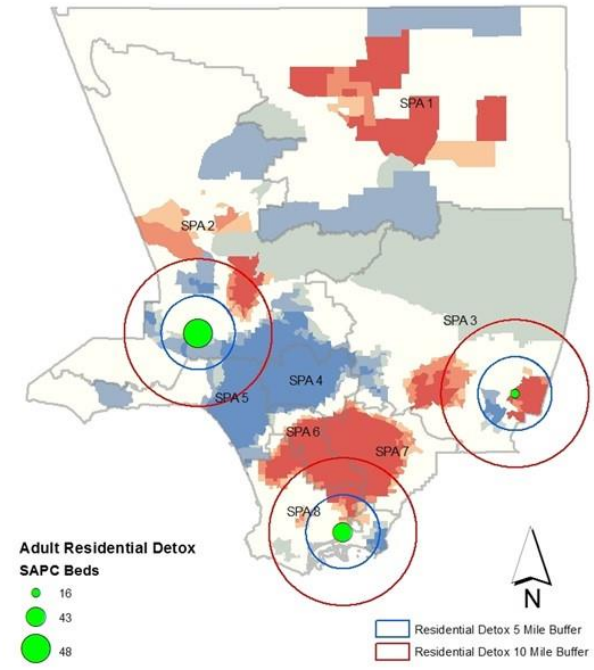


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	10,245
Estimated utilization	14,192 (16%)
Patients per bed per year	6*
Total beds needed	2,365
SAPC bed capacity	1,220
Additional Beds needed	1,145
Non-contracted beds	697
Additional beds needed after using unfunded beds	448
Number of Facilities	75

*Patients 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).

Figure 9: Adult Residential Medical Detox – Medium Utilization Estimate

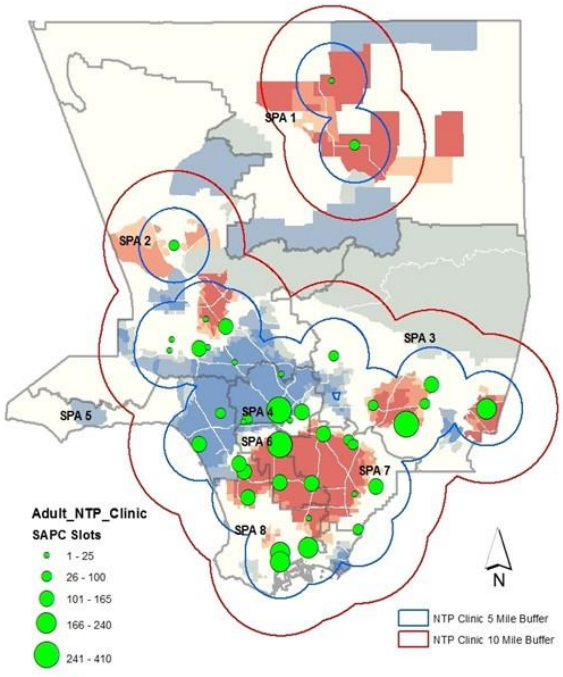


Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Bed Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	4,200
Estimated utilization	6,209 (7%)
Patients per bed per year	40*
Total beds needed	155
SAPC bed capacity	107
Additional beds needed	48
Non-contracted beds	0
Additional beds needed after using unfunded beds	48
Number of Facilities	3

*Patients 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.

Figure 10: Adult Opioid Treatment Program – Medium Utilization Estimate



Red areas indicate the highest concentration of DMC eligible people;
Blue areas indicate the lowest concentration of DMC eligible people.

Slot Utilization and Capacity	Number
Total estimated utilization	88,698
Current utilization	13,299
Estimated utilization	21,288 (24%)
Patients per slot per year	3*
Total slots needed	7,096
SAPC slot capacity	5,373
Additional slots needed	1,723
Number of Facilities	39

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

DPH-SAPC currently contracts with community-based organizations to provide all LOCs and directly operates one residential facility and outpatient program (AVRC) for adults. Facilities may serve youths only, adults only, or youth and adults. Currently, approximately 52 percent of outpatient, 55 percent of intensive outpatient, one percent of residential, 88 percent of opioid treatment program, and zero percent of withdrawal management sites are currently DMC certified. DPH-SAPC is actively working with contractors who provide residential services to obtain DMC certification/licensure as soon as possible, and all contracted agencies and sites will be required to obtain the appropriate DMC certification/licensure by July 1, 2017. DPH-SAPC is able to provide each LOC described in the benefit package within the County, but expansion will be needed to ensure adequate access and availability by age population, especially for youth (Table 4, Attachment 3). Efforts will be made by the County to include other appropriate treatment service agencies countywide that can fill LOC gaps for youth; thereby, eliminating the need to refer a youth to neighboring counties.

Table 4: Number of Contracts and Sites by Population Served

Level of Care	DMC Certified		Non-DMC Certified		Total # Agencies (N=93)	Total # Sites (N=383)
	# of Agencies	# of Sites	# of Agencies	# of Sites		
Youth Serving Only						
Outpatient	0	0	7	7	7	7
Intensive Outpatient*	0	0	0	0	0	0
Residential	0	0	1	1	1	1
Youth and Adult Serving						
Outpatient	6	10	2	2	8	12
Intensive Outpatient	0	0	0	0	0	0
Residential	1	1	2	3	3	4
Adult Serving Only						
Outpatient – General	44	85	26	84	61	169
Outpatient – Perinatal	14	21	7	13	20	34
Intensive Outpatient – General	22	31	12	28	30	59
Intensive Outpatient – Perinatal	12	15	6	9	16	24
Residential – General	0	0	39	94	39	94
Residential – Perinatal	0	0	7	14	7	14
Residential – Detox	0	0	3	4	3	4
Opioid Treatment – General	16	39	2	6	17	45
Opioid Treatment – Perinatal	1	4	0	0	1	4
Recovery Residence-Perinatal	0	0	9	53	9	53
Recovery Residence	0	0	9	14	9	14

* The report used to generate this table is based on contract type, therefore, it is likely that youth contractors provide non-DMC certified intensive outpatient services but it was not captured based on available data.

According to DHCS information, state-licensed residential treatment and residential detoxification programs have a total of 5,895 beds available in Los Angeles County, including those already contracted by the DPH-SAPC. A total of 277 state-certified non-residential treatment programs operate in the County, including those already contracted by the DPH-SAPC. Therefore, there exists a large inventory of outpatient services and residential beds that presently are not contracted by the County. While some of this capacity is likely committed to other purchasers of services, such as the State correctional system and commercial health insurance plans, it is likely that a substantial inventory remains unfunded and demonstrates potential for DMC certification to support expanded service needs as DMC-ODS is implemented.

Efforts are underway to better define requirements for site-specific certification and to increase the number of SUD network providers with the DMC certification. The greatest concern for the County, however, is the timeliness with which the State is able to process new DMC applications, particularly for residential services. Until DPH-SAPC's network providers of residential services are DMC-certified, these benefits must be funded under other capped funding sources, which limit the number of available treatment beds, causing patients to be served in LOCs below what is determined to be medically necessary. As a result, both the County and State may be at risk for liability by not providing adequate medically determined LOCs.

Additional Accessibility Factors

While increasing the availability of services in underserved parts of the County is essential to increasing rates of SUD treatment and improving health outcomes, so is meeting the needs of beneficiaries in terms of flexible hours of operation, services in their preferred language, the ability to receive services when needed, and easily accessible locations (non-clinic based, proximity to home/work). DPH-SAPC will encourage and assist SUD network providers to continually take steps to provide services that meet beneficiaries' needs and preferences, but at minimum this includes the following standards:

- Hours of Operation: All outpatient and intensive outpatient services will operate at least five days a week (including one weekend day), and at least two days will include evening hours (5:00 PM to 9:00 PM, at a minimum). Residential programs will operate 24 hours per day, seven days a week, and will accept intakes at least during regular weekday business hours (9:00 AM to 5:00 PM). Assuming financial feasibility in terms of the ability to support necessary workforce and infrastructure investments, DPH-SAPC will work with its network of providers to expand hours of operation in both outpatient and residential settings, with particular focus on expanding access to intake appointments on the weekend by July 2018.

- Language Capability: Currently about 71 percent of DPH-SAPC contracted sites offer bilingual services and 68 percent of them are in Spanish, according to the provider survey. Services will be provided in all threshold languages as needed. All network providers serving populations in which a majority of patients are monolingual/bilingual Spanish speakers will be required to provide services in Spanish. Services in other languages may be offered by specific programs that serve specific cultural populations. The County also maintains a contract with Interpretation Services that provides oral interpretation services in at least the 12 threshold languages (other than English) as indicated by the Medi-Cal Eligibility Data System (MEDS) that is accessible to all of its network providers. These languages are: Arabic, Armenian, Cantonese, Farsi, Khmer (Cambodian), Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese and other Chinese. DPH-SAPC recognizes the importance of ensuring the availability and accessibility of services that can effectively serve individuals with diverse backgrounds and needs, and therefore will fully comply with State requirements regarding delivery of services in compliance with 42 CFR 438.206(c)(2).

- Timeliness of Services:

  First face-to-face visit – The Beneficiary Access Line will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than three business days from the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services), the assessment/intake with a qualified SUD network provider that is geographically accessible will be conducted within 15 business days from the initial brief triage assessment; beginning in July 2017 the assessment/intake target

will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018.

For individuals that present at the provider site first, the same timeliness expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Waitlists will be tracked with the automated appointment system that is expected to be ready by July 2017. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. DPH-SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Emergencies – For emergency situations when an individual presents either in-person or on the phone with life-threatening condition, the Beneficiary Access Line or network provider will immediately contact emergency medical services for intervention. Network providers will be required to establish procedures for appropriately handling urgent conditions presented by actively enrolled beneficiaries.

Afterhours care – Network providers will be required to establish procedures for appropriately handling afterhours care needs of actively enrolled beneficiaries. In addition, the patient may contact the Beneficiary Access Line for a referral to an agency that provides 24 hour care or assistance.

- Geographic Location of Providers: A criterion for making referrals for placement in outpatient services will be that the program should be within 30 minutes travel time by personal or public transportation, or 10 miles to and from the beneficiary's location of choice. In some outlying semi-rural areas of the County such as in the Antelope Valley, the low population density may make this criterion impossible to meet, particularly through public transportation, however the target will be within one-hour travel time whenever feasible. In such cases, every effort will be made to accommodate the beneficiary to minimize excessive travel time.

  Telehealth approaches will also be considered after the initial 12-month implementation period as a means to expand access to services for beneficiaries in outlying areas and for those with transportation challenges.

All County-contracted SUD network providers will be fully compliant with the Americans with Disabilities Act requirements as a contract provision.

9. TRAINING PROVIDED

What training will be offered to providers chosen to participate in the Waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Review Note: Include the frequency of training and whether it is required or optional.

All network providers will be required to establish and operate an employee training plan for their employees that includes a training needs assessment and describes steps to ensure that employees receive appropriate training aligned with their responsibilities, clinical or otherwise. At minimum, this includes training on the ASAM Criteria, DSM-V, Motivational Interviewing, Cognitive Behavioral Therapy, Culturally and Linguistically Appropriate Services (CLAS), and clinical documentation for all direct service staff at the frequency prescribed by DPH-SAPC. Network providers will be monitored at least annually for compliance with this contract requirement, including ensuring compliance with the minimum number of annual training hours (currently 24 hours per direct service staff) and receipt of booster sessions for the above listed core trainings in accordance with the employee training plan and County requirements.

In addition, DPH-SAPC will be responsible for assessing overall network clinical training needs and coordinating training sessions in alignment with providers' training needs assessment findings. Contracts with the California Institute for Behavioral Health Solutions and the UCLA-Integrated Substance Abuse Programs serve as the primary vehicles for provision of clinical and program capacity-building training, and technical assistance for its network providers. Current training topics identified for the DMC-ODS implementation include the following: application of the ASAM Criteria and determination of medical necessity, clinical documentation, and evidence-based practices (Motivational Interviewing, Cognitive Behavioral Therapy, and Medication-Assisted Treatment). Additional trainings topics (e.g., CLAS, data integrity) will also be offered in the future to better ensure a well-trained and capable workforce. The County will use a train-the-trainers approach to build a cadre of highly skilled medical directors and clinical supervisors within the provider network who will then train employees within each provider organization and monitor fidelity to adopted evidence-based practices. To accommodate the diversity and size of the County-contracted SUD provider network and its workforce, training will be continuous throughout the demonstration period and beyond.

10. TECHNICAL ASSISTANCE

What technical assistance will the county need from DHCS?

The County requests technical assistance from the State on the following topics:

- How DMC minor consent restrictions (e.g., parental consent) relate to the ability of minors age 12 and above to consent to treatment per California Family Code 6929, including balancing parental involvement and privacy concerns for minors receiving treatment.

- How to obtain reimbursement for SUD services under Early Periodic Screening, Diagnosis and Treatment (EPSDT), including what service billing codes should be used.

11. QUALITY ASSURANCE

Describe the quality assurance activities the county will conduct. Include the county monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438 requirements. Please also list out the members of the Quality Improvement committee. Also, include descriptions of how each of the quality assurance activities will meet the minimum data requirements.

The County established a *Quality Improvement and Utilization Management (QI/UM) Plan* in consultation with its provider network and stakeholders, and in compliance with DMC-ODS requirements (Attachment 4). The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration.

Quality Improvement Program

The purpose of the QI program is twofold: 1) to establish an infrastructure for quality-focused services through the formation of a number of committees that focus on specific aspects of an organized delivery system of SUD services; and 2) to set standards in areas such as medical necessity criteria, clinical practice (including medication-assisted treatment), and LOC guidelines as founded on the ASAM Criteria. The components of these QI standards will also focus on performance and outcome measures, care coordination, workforce standards, risk management, Quality Improvement Projects (QIP) at the provider level, and a grievance and appeals process. SUD measures will monitor key quantitative and qualitative characteristics of the system of care including, but not limited to:

- Timeliness of first face-to-face appointment;
- Timeliness of services for urgent conditions;
- Timeliness of first dose of NTP
- Frequency of follow-up appointments;
- Access to afterhours care;
- Responsiveness of the beneficiary access line;
- Strategies to reduce avoidable hospitalizations;
- Coordination of physical and mental health services at the provider level; and
- Assessment of the beneficiaries' experiences.

The QI program will establish various committees including: Quality Improvement/Risk Management (QI/RM), Utilization Management, Research and Data Management, Professional Development, Community Liaison (with subcommittees for providers and

consumers), and Cultural Competence. The QI/RM Committee will meet every other month and consist of DPH-SAPC representatives from each major division/unit, including the Director's Office, Office of the Medical Director and Science Officer, Adult and Youth Programs, Contracts, Strategic Planning, Information Systems, Finance, and the evaluation services contractor who will be collaborating with DPH-SAPC on quality assurance and training activities. The QI/RM Committee will work closely with all other committees in order to incorporate feedback into the continuous quality improvement process.

The QI program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: access to care, workforce, documentation, medical necessity criteria, clinical practice guidelines, levels of care guidelines, recovery support services, case-management/care coordination, performance and outcome measures, peer review quality improvement projects, confidentiality risk management, and complaints/grievances and appeals process. This attachment also describes how these activities will meet the minimum data requirements of the DMC-ODS.

Utilization Management Program

The UM program analyzes how the DPH-SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established eligibility and medical necessity criteria; ensuring that clinical care and ASAM LOC guidelines are followed; conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services; authorization of select services; random and retrospective monitoring of a portion of provider caseloads; and ongoing monitoring and analysis of provider network service utilization trends. In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum
- To assure fair and consistent UM decision-making
- To focus resources on a timely resolution of identified problems
- To assist in the promotion and maintenance of optimally achievable quality of care
- To educate health care professionals on appropriate and cost-effective use of health care resources.

Provider caseloads for youth and adults at each ASAM LOC will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization. UM staff may also conduct focused chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted onsite and without prior notice to the provider. Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC QI/RM Committee immediately.

The UM Program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: eligibility and medical necessity review process and clinical case review process.

Compliance with CFR 438

The QI/UM plan is in compliance with CFR 438.200, 438.202, and 438.204. The QI/RM Committee that is built into the QI program will conduct periodic reviews to ensure ongoing compliance. DPH-SAPC will ensure compliance with CFR 438 Subpart E by appropriately addressing any quality related concerns identified by the DHCS contracted External Quality Review Organization that will conduct annual reviews of the SUD services provided within this system of care. DPH-SAPC will also conduct the various monitoring processes described above, and comply with data reporting requirements.

12. EVIDENCE-BASED PRACTICES

How will the counties ensure that providers are implementing at least two of the identified evidence-based practices? What action will the county take if the provider is found to be in non-compliance?

The County will require that its network providers implement and use, at minimum, the evidence-based practices of Cognitive Behavioral Therapy and Motivational Interviewing by July 2016. In addition, network providers will be encouraged to adopt additional evidence-based practices and promising practices tailored to the needs of each provider's focus patient population. Implementation of these evidence-based practices will be a contract requirement and monitored through the contract compliance monitoring process. In accordance with current contract language and monitoring guidelines, Contract Services Division will oversee and conduct at minimum annual site visits to ensure evidence-based practices are being conducted effectively and with fidelity. Any non-compliance issues with be addressed with appropriate provider staff and resolved through a corrective action plan, up to and including contract termination. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

13. ASSESSMENT

Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?

Beneficiaries will be first engaged in a brief triage assessment by the Beneficiary Access Line or at the SUD provider site to establish the provisional LOC recommendation. The beneficiary will then be assessed by the contracted SUD treatment provider for medical necessity and appropriate LOC based on the ASAM Criteria. SUD treatment providers will be required to have LPHAs determine medical necessity, Clinical staff (e.g., registered interns, certified counselors, LPHAs)

will be trained on and required to use the ASAM Criteria for placement decisions, continued service, and transfer/discharge. The County will encourage all providers to use the ASAM Continuum Software (ASAM-CS), which at the present time only pertains to the adult population, although paper-based assessment based on the ASAM Criteria will also be allowable if the tool is pre-approved by the County.

Contract monitoring and the UM program will provide a multi-layered approach to ensuring that beneficiaries are placed at the appropriate LOC. Providers will be required to maintain a record of ASAM assessments. Case reviews conducted as part of UM activities will ensure appropriate LOC placement at the initial assessment, and for purposes of continued service and transfer/discharge.

14.REGIONAL MODEL

If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

Los Angeles County will not be implementing a regional model.

15.MEMORANDUM OF UNDERSTANDING

Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 4(i) of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

MOUs between the DPH-SAPC, the two Medi-Cal managed care plans (Health Net and L.A. Care), and DMH are in the process of execution and will be submitted within 90 days of the approval of the County implementation plan as required. The MOU will include all conditions as required by the State (Attachment 2). DPH-SAPC has already executed MOUs describing care coordination policies and procedures with the health plans and DMH for the Cal MediConnect program.

16. TELEHEALTH SERVICES

If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

Some County-operated and contracted SUD providers currently offer telehealth services, including telepsychiatry. DPH-SAPC will encourage all SUD providers to expand or introduce telehealth as an offered service, and will explore telehealth as a means to expand the availability of medication-assisted treatments, physician consultations, and services for special populations, among other services. DPH-SAPC will also explore increased collaboration with DMH and Medi-Cal managed care plans in an effort to expand these services. All telehealth services offered at County-contracted SUD providers will be required to use special equipment and/or software that meets telehealth encryption standards and that can ensure confidentiality. The telehealth equipment will be set up in a private room that is locked and secure.

17. CONTRACTING

Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

The County establishes master agreements with qualified community-based SUD service providers through a selective contracting process. Once master agreements are executed with providers that meet County requirements, contracts are established with these legal entities who demonstrate capabilities and capacities to provide one or more of the ASAM LOCs included in Los Angeles County's benefit package for youth and/or adults. Using this approach, the County ensures that its network providers each possess the business, clinical, and specific patient populations capacities and competencies to effectively provide the contracted services; and that the service network has the optimal capacity of service providers to meet the needs of the County population. A listing of all contracted providers including information on service modality and provider address is attached as required (see Attachment 3).

Contract Term

All contracts will have a term of three years, with the option to extend on an annual basis. SAPC will utilize current contracts to initiate participation in the waiver while developing a new Request for Service Qualifications and associated Work Order Solicitations to expand the number of DMC certified LOCs throughout the County and to more thoroughly incorporate the new contract expectations that come with this system transformation. The new contracts are anticipated to have a five year term with up to five one-year extensions based on provider

performance and need. All SUD network providers will be required to be DMC-certified for contracted LOCs by July 2017.

Appeals Process

Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective contractor may request a review of the requirements under a solicitation for a Board-approved services agreement. Additionally, any actual contractor may request a review of a disqualification under such a solicitation. The appeal process will follow the Los Angeles County Protest Policy (available at: http://mylacounty.info/listserver/pcs_contracts/cms1_19157.pdf).

Continuity of Services

Any current SUD provider not awarded a contract, or who is terminated as a contractor, will be notified at least 30 days prior to contract termination. Provider experience, quality, and history in terms of the provision of care, fraud, waste, and abuse will be components of the decision-making process when awarding or terminating contracts. In accordance with existing contract language, such providers shall make immediate and appropriate plans to transfer or refer all current patients to SUD network providers for continuing service in accordance with the patient's needs. Such plans shall be approved by DPH-SAPC before any transfer or referral is completed except in those instances, as determined by SUD provider, where an immediate patient transfer or referral is indicated. In such instances, the SUD provider may make an immediate transfer or referral to the nearest SUD network provider.

18. ADDITIONAL MEDICATION-ASSISTED TREATMENT

If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

In addition to medications used by Opioid Treatment Programs (methadone), the County will offer to its beneficiaries all addiction medications approved by the Food and Drug Administration as determined medically necessary. These medication-assisted treatments (MAT) include acamprosate, buprenorphine, disulfiram, naloxone, and naltrexone (oral and extended release formulations). Addiction medications are prescribed and administered by qualified SUD network providers or through coordination with the beneficiaries' Medi-Cal managed care health plan network pharmacy and primary care providers. Currently, within the SAPC network of providers access to MAT occurs via a "hub and spoke" model in which providers with patients who may benefit from MAT refer those patients to one of three MAT "hubs" capable of prescribing MAT. Throughout the demonstration period, DPH-SAPC will explore opportunities to expand access to MAT, either through the expansion of the current MAT hub network, utilizing telehealth, or by facilitating regional networks of providers who collectively fund and share a local MAT prescriber. The MAT hub network currently consists of three "hubs" with the infrastructure and staffing to provide MAT, including methadone, buprenorphine, naltrexone, and other MAT. MAT hubs accept both internal referrals from within their agency, as well as external referrals from other SUD providers who have identified a

beneficiary who is interested and appropriate for MAT. These MAT hubs expand access and availability of MAT to a diverse pool of SUD providers as the County continues to work to expand MAT by increasing the number of MAT hubs and MAT prescribers both within the SUD system of care, and within the physical and mental health systems.

19.RESIDENTIAL AUTHORIZATION

Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

Initial Authorization: The County has establish written policies and procedures describing required prior authorization for initial admission to residential services within 24 hours of a network provider's prior authorization request submission in compliance with DHCS requirements. If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss whereas authorization approvals will be retroactively reimbursed to the date of admission. An automated tracking system will compile the number, disposition, percentage, and timeliness of requests for pre-authorization.

Continuing Authorization: The County will establish written policies and procedures for processing requests for continuing authorization of residential services. Residential services for all adult populations will require reauthorization after 60-calendar days to assess for appropriate LOC utilization. If a one-time extension is warranted, youth residential services will require reauthorization after 30-calendar days to assess for appropriate LOC utilization. Requests for continuation of residential services must be submitted at least seven calendar days in advance of the end date of current authorization for both adult and youth populations. There will be a maximum residential treatment limit of 90-days for adults and 30-days for adolescents, unless medical necessity warrants a one-time extension of up to 30-days on an annual basis. For adult populations, only two non-continuous 90-day regimens will be authorized in a one-year period. For perinatal and criminal justice populations, a longer length of stay of up to six months on an annual basis may be approved based on medical necessity, but only three months with a one-time 30-day extension of the total episode can be funded under DMC.

Residential patients must receive regular assessments of their progress within these 60- and 30-calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower LOC as soon as clinically indicated. Required treatment plan updates every 30-days will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate.

If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned

considerations, UM Unit will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower LOC. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all LOC transitions. Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within 24 hours.

20. ONE YEAR PROVISIONAL PERIOD

For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC-ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

Not applicable for Los Angeles County, as all mandatory requirements are met upon implementation.

County Authorization

Authorization of County Alcohol and Other Drug Program Director:

	Los Angeles	
Wesley L. Ford, Deputy Director Bureau of Health Promotion Department of Public Health	County	Date