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SAPC INFORMATION NOTICE 21-09
Supersedes IN 21-05

October 7, 2021

TO: Los Angeles County Substance Use Disorder Contracted Treatment Network Providers

FROM: Gary Tsai, M.D., Division Director
Substance Abuse Prevention and Control

SUBJECT: **FISCAL YEAR 2021-2022 RATES AND PAYMENT POLICY UPDATES**

The Department of Public Health's (DPH) Division of Substance Abuse Prevention and Control (SAPC) received approval from the California Department of Health Care Services (DHCS) to modify the Fiscal Year (FY) 2021-2022 Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver rates for all levels of care, except Opioid Treatment Programs (OTP) and Medication Assisted Treatment (MAT) Reimbursement Rates, as the State sets these rates. This Information Notice (IN) outlines the implementation of the new rates and corresponding standards as outlined in the FY 2021-2022 Rates and Standards Matrices, effective July 1, 2021 and includes other payment-related matters.

Rate Increase Overview

American Society of Addiction Medicine (ASAM) levels of care (LOC) rates increased to continue the shift of the specialty Substance Use Disorder (SUD) system towards parity with mental and physical health systems and to enable Network Providers to invest in improved patient outcomes and experience. SAPC procured an actuarial firm to evaluate FY 2020-2021 rates relative to other DMC-ODS counties, other government payors, market rates for commercially covered like-services, and interim cost reports voluntarily submitted by some providers.

For FY 2021-2022:

- SAPC is returning to a standard base rate model for services, which removes staff modifiers for all LOCs.
- Nearly all DMC base rates for reimbursable services are increasing, including by the allowable Medicare Market Basket Inflator of 2.3% for all LOCs.
- SAPC continues to implement increases above the base rate for perinatal (+7.81%) and youth (+2.14%) specialized programs; documentation time for all LOCs; and travel time for approved field-based services.

FY 21-22 Changes over Standard Base Rate	
ASAM 1.0 – Outpatient	+ 15.6%
ASAM 2.0 – Intensive Outpatient	+ 14.4%
ASAM 3.1, 3.3, 3.5 – Residential	+ 8.4%
ASAM 1-WM, 2-WM, 3.2-WM	+ 2.3%
ASAM 3.7-WM*	+12.5%
ASAM 4-WM*	+11.9%
Case Management	+ 5.8%
Recovery Support Services	+ 33.0%
Opioid Treatment Programs	Not Applicable

*An increase was applied to ASAM 3.7 WM and ASAM 4.0 WM to include the costs to deliver case management as a component of the day rate

Population Modifiers

DHCS requires programs specializing in serving pregnant and parenting women (PPW) and youth to comply with the Perinatal Practice Guidelines and Youth Treatment Guidelines, respectively. This enhanced rate is designed to continue to help providers meet these expectations, in addition to other local requirements (i.e., pregnancy intention services within PPW programs). Each Network Provider site that meets the criteria as a PPW or youth-tailored program, which includes identification as such on the Service and Bed Availability Tool (SBAT), is eligible for this enhanced rate for allowable DMC-ODS services. These modifiers do not apply to supplemental PPW services for transportation and childcare as these rates are set by Federal and State entities. PPW sites that also serve pregnant/parenting youth only receive the PPW modifier.

SAPC is developing enhanced guidelines for PPW and youth services in collaboration with network providers that will be required for continued receipt of increased rates and participation as a specialized service location.

SITE QUALIFICATIONS FOR POPULATION MODIFIERS		
Population Modifier	**Criteria**	**Increase**
Youth 12-17 years of age "HA"	• Experience serving youth (ages 12 through 17) in 2 of the last 7 years. • Demonstrated experience using evidence-based practices that are specific to youth. • Counselors and/or Licensed Practitioner of the Healing Arts (LPHA) providing direct SUD treatment services to youth, young adults and families have a minimum of 2 years' experience providing youth services, which includes working with youth who are runaways, victims of abuse and pregnant or with children. • Policies and procedures for addressing the needs of youth with SUD, such as ensuring developmentally appropriate services, family involvement, composition of group counseling, etc. • Network Provider owner, key staff, and all individuals providing direct services to youths passed a background investigation to the satisfaction of County. • Listed on the SBAT as a qualified site.	2.14%
Pregnant or Parenting Women "HD"	• Current DMC certification for perinatal services. • Counselors and/or LPHAs providing direct SUD treatment services to perinatal women must have minimum of 2 years of experience providing women- specific evidence-based or best practices which includes, but is not limited to: Trauma-Informed and Integrated Trauma Services, relational or cultural approaches that focus on the relevance and centrality of relationships, assessing and reviewing the history of interpersonal violence, women-only therapeutic environments, parenting support, parenting skills, and family reunification services as applicable. • Listed on the SBAT as a qualified site.	7.81%

Telehealth and Telephone Services

Effective November 1, 2021, services provided via telehealth or telephone services must include the appropriate modifier and place of service code.[1] There is a maximum of four modifiers that can be applied to a claim. In instances where the telephone or telehealth modifier is needed and supersedes the four modifier max, instruction is to drop the youth modifier HA.

	Place of Service Code	Modifier
Telehealth	02	GT
Telephone	02	SC

[1] DHCS Behavioral Health Information Notice 21-047

Documentation Time

To support Network Providers' ability to effectively document delivered services, practitioners will be able to claim the amount of time required to draft the note in the EHR as follows, and commencing upon Sage configuration unless otherwise noted in the attached instructions form:

Service-Based LOC: For ASAM 1.0 and 2.1, up to 10-minutes of documentation time per patient for group services using 1-minute increments and up to 15-minutes for individual services in 15-minute increments.

Day Rate-Based LOC: For ASAM 3.1, 3.3, 3.5, 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM, SAPC incorporated the cost of documentation into the daily rate. Separate claim submissions are not permitted. Daily or per service notes are now required for these levels of care; the weekly note allowance has been discontinued effective July 1, 2020.

Per DHCS, and as outlined in the DMC-ODS State-County Intergovernmental Agreement, timespent (e.g., start and end time) documenting service delivery must be included in a Progress Note or Miscellaneous Note in addition to the time spent (e.g., start and end time) conducting the service to avoid disallowance. SAPC will monitor this requirement.

Travel Time

When providing Outpatient (ASAM 1.0) or Intensive Outpatient (ASAM 2.1) treatment servicesfor at least 60-minutes at a SAPC approved Field-Based Service location, the performing provider (e.g., SUD Counselor) will be able to add travel time to and from the approved location, up to 30-minutes each way, unless otherwise approved in the Field-Based Service application and based on a SAPC identified gap in network adequacy (e.g., Catalina Island). The Progress Note or Miscellaneous Note must include the start and end time of the travel in each direction in addition to the start and end time of the direct service.

Screening and Referral Connections

To improve the patient experience and reduce unnecessary paperwork, any individual who first presents at a Network Provider must receive either the electronic Youth Engagement Screener (ages 12 through 17) or ASAM CO-Triage screener (18 years of age and older) to determine the Provisional LOC prior to receipt of the full ASAM assessment. Providers must also complete the *Referral Connections Form* in the Sage system, which outlines attempts to make an appointment for a full ASAM Assessment and the associated outcome. The maximum payment per patient per day per provider agency is $30.00 in all LOCs. The screening is not separately reimbursable when also claiming the Clinical Day rate on the same day.[2]

A Youth Engagement Screener or CO-Triage screening is not reimbursable when referrals originate from the Client Engagement and Navigation Services (CENS), Connecting to Opportunities for Recovery and Engagement (CORE) Centers, or the Substance Abuse Service Helpline (SASH).

[2] Day Rate Based LOCs include ASAM levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, 4-WM, 3.1, 3.3, 3.5.

Residential Treatment Services

Pursuant to new State guidelines[3], DMC now reimburses for medically necessary residential treatment and does not stipulate limits related to number of admissions or duration of stay for any Medi-Cal enrolled beneficiary. Therefore, residential admissions for Medi-Cal beneficiaries need to have a corresponding authorization under the DMC funding source.

Case Management Services

Case Management is a collaborative and coordinated approach to the delivery of health and social services that connects and coordinates appropriate needed services to address specific concerns and barriers to meet treatment plan goals on behalf of the patient. Effective January 1, 2021, SAPC removed the 10-hour or 40-unit per month maximum cap for Case Management Services (H0006) for patients meeting medical necessity criteria. The standalone uncapped benefit applies to most Levels of Care, with the exception of Withdrawal Management Levels 3.7, and 4, where the benefit is incorporated into the day rate and is not a separate billable service. Case Management services may be delivered face-to-face, by telephone or through telehealth supportive services.

Recovery Support Services

The rate for Recovery Support Services benefit has been standardized across all service components except for Screening and Case Management. The Sage system is also being configured to comply with new State guidance[4] that now permits concurrent enrollment in a treatment LOC and serving beneficiaries without a remission diagnosis.

The Sage system will be configured to allow Recovery Support Services to be authorized through a provider authorization which does not require a SAPC utilization management review prior to provider billing for services. Providers are still responsible for conducting medical necessity evaluations and documenting rationale for level of care determination in the clinical record. Through this process providers will be issued Provider Authorizations (PAUTH) with the appropriate Recovery Support Services U codes and previous level of care U code combinations needed to ensure proper adjudication. Providers are instructed to claim using the U code for the DMC certified level of care of the site where the Recovery Support Services was delivered.

Recovery Bridge Housing

Recovery Bridge Housing (RBH) rates for adult and PPW locations continue at $50.00 and $55.00 per person per day, respectively. Children accompanying the parent in a qualified PPW program are reimbursed at the same rate as the parent. Additional information on the PPW benefit is included in the Pregnant and Parenting Specialization Enhanced Rates and Staffing Modifiers matrix and the most current version of the Provider Manual.

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[3] DHCS Behavioral Health Information Notice 21-021
[4] DHCS Behavioral Health Information Notice 21-020

Room and Board

The Room and Board rate remains $25.00 for all LOCs. This will require residential and withdrawal management sites to reevaluate how claims are allocated during cost reporting. If you have any questions, please reach out to your SAPC Finance Analyst.

Opioid Treatment Programs

National Drug Codes

Under the DMC-ODS, OTPs must offer Buprenorphine-Mono, Buprenorphine-Naloxone, Disulfiram, and Naloxone in addition to methadone.[5] The National Drug Code (NDC), according to DHCS' Information Notice 19-033 and the NDC MAT List, must be included in all claims for additional Medications for Addiction Treatment (MAT), excluding methadone, beginning
July 1, 2019. Furthermore, to enable Buprenorphine prescribing, qualified prescribers must have the required Drug Enforcement Administration (DEA) X-Waiver.

Counseling Requirements

Patients in OTP settings can receive individual and/or group counseling in excess of 200 minutes (20 10-minute increments) per month if medically justified and documented in the beneficiary record.[6]

HIV and HCV Testing

DHCS factored in the cost to conduct the Human Immunodeficiency Virus (HIV) and the Hepatitis C Virus (HCV) tests within the OTP rates. As such, this service must be documented via the claims system at a $0.00 rate value.

Client Engagement and Navigation Services (CENS)

CENS hourly rate for approved co-locations continues at $73.70 per CENS counselor which continues to support documentation and transportation requirements.

ASAM 1.0 AR

Until SAPC receives further State guidance on how to submit DMC claims for individuals 12 through 20 years of age who are at-risk of but do not meet criteria for a SUD diagnosis, member authorizations are suspended and should not be submitted to the Quality Improvement and Utilization Management Unit for review or Sage for claims reimbursement. Authorized Youth Network Providers can continue to submit paper-based claims to SAPC in accordance with the letter titled "Youth At-Risk Memo" dated June 9, 2021. The paper-based process will sunset for DMC reimbursable claims once the payment process has been established within Sage.

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[5] DHCS MHSUDS Information Notice 18-036 or as subsequently modified by the State
[6] DHCS MHSUDS Information Notice 15-028 or as subsequently modified by the State.

Medi-Cal Application or Transfer Pending

SAPC is continuing the "Pending Medi-Cal Enrollment and Transfer Allowance" intended to ensure that the SAPC treatment provider network does not deny admission to SUD treatment for patients who are presumed to meet the eligibility criteria for Medi-Cal or My Health LA. The policy allows providers to receive reimbursement in advance for patients who are eligible and in the process of applying for Medi-Cal or whose benefits need to be transferred from another County to Los Angeles County. This is permitted for up to thirty (30) consecutive calendar days for new patients who have not already been a recipient of this opportunity at another LOC within the same network provider or at another network provider site during the fiscal year (**limit one per patient per fiscal year system-wide**). It does not, however, apply to patients whose Medi-Cal benefits lapsed during the treatment episode.

Because Medi-Cal benefits are generally retroactive to the date of application submission, providers must help patients submit their Medi-Cal application or transfer as soon as possible during the admission process. The provider is expected to conduct case management for this purpose and continue delivering services after the 30-day period while Medi-Cal is pending. Additionally, Medi-Cal or My Health LA-eligible beneficiaries/participants may not be charged sliding scale fees or flat fees.

Providers are required to ensure that the *Financial Eligibility Form* in Sage reflects the funding sources available to patients, including both non-DMC and DMC funding. Once Medi-Cal is obtained, the provider must change the *Financial Eligibility Form* in Sage to indicate DMC as the primary payor as this enables previously non-submitted claims to be sent to the State for payment. SAPC will be monitoring and enforcing this policy to ensure that providers are enrolling patients into the appropriate funding source. SAPC will use both technical assistance and compliance measures to support this enforcement.

Authorization Submission Deadline

Member authorizations and reauthorizations must be submitted to the SAPC Quality Improvement and Utilization Management Unit within thirty (30) calendar days of admission or within thirty (30) calendar days of the start date of reauthorizations. This aligns with local requirements to complete initial assessments within seven (7) days of admission for adults and fourteen (14) days for youth. This also limits financial liability and recoupment potential by ensuring completion of assessments and Treatment Plans within State DMC deadlines. SAPC is in the process of determining implication and possible changes to this process as a result of recent State guidance[7] and will update providers accordingly.

Member authorizations and reauthorizations submitted after thirty (30) calendar days of the admission date or reassessment date may result in determinations that medical necessity was not established according to both State and SAPC contract requirements. In this scenario, only those services provided after medical necessity is established will be reimbursed.

[7] DHCS Behavioral Health Information Notice 21-019

Cost Reconciliation

Beginning on July 1, 2021, SAPC will resume the cost reconciliation process and settle FY 2021-2022 at the lesser of costs or charges for treatment services except as superseded by SAPC COVID-19 Information Notices.

Resources

The DPH-SAPC Provider Manual, the Sage 837P Companion Guide, and Sage 837ICompanion Guide include additional details on Network Provider requirements, including treatment and billing requirements.

Effective Period

This guidance will be effective starting July 1, 2021 through June 31, 2022 unless otherwise revised.

Additional Information

Questions or requests for additional information should be sent to Michelle Gibson, Deputy Director for Treatment Services at (626) 299-3244 or migibson@ph.lacounty.gov with copy to Julia Sandoval at jsandoval@ph.lacounty.gov.

Attachments

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