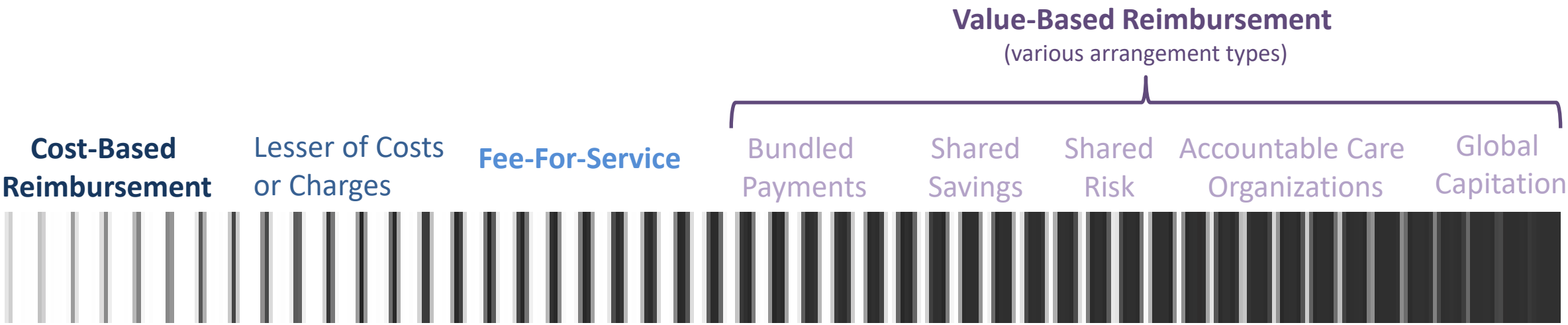
CalAIM, Payment Reform, & Beyond – The Specialty SUD System in Los Angeles County

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

Outline

- **Behavioral Health Payment Reform**
  - Impact on SUD Providers
- **CalAIM & Beyond: What's Next for LA County's Specialty SUD System?**
  - Behavioral Health Administrative Integration
  - Ongoing Shift Toward Managed Care Plans
  - SUD Workforce Issues
  - Housing & the SUD System
  - Challenge & Opportunities
- **Discussion**

Behavioral Health (BH) Payment Reform



The PAST:
Transition from Pre- to Post-DMC-ODS

The PRESENT:
Transition from DMC-ODS to BH Payment Reform under CalAIM

The FUTURE:
Transition from FFS to some form of value-based reimbursement (aka: pay-for-performance), possibly via an incentive-based approach with quality benchmarks

BH Payment Reform – Key Changes

1. **The State (DHCS) will set rates for counties and counties will then set rates for providers**
   - The overall goal of BH payment reform is to fund the system we want in the future, not necessarily the system we have today.
     - Where the State sets its rates for counties will be key in determining if and when this aim can be achieved.
     - Rates will be set based on a number of factors, including cost survey data, wage data, and potentially inflators.
   - Process:
     - DHCS will seek approval for its rate methodology from federal partners (CMS)
     - Federally approved rates will be set by county region (LA County is its own region and will have its own rates)
     - Counties will then set rates for its providers, including OTPs and non-OTPs
       - » Counties will be looking for ways to incentivize quality, possibly through retaining a portion of the State rates to implement quality incentives whereby providers can draw down incentive payments on top of their base rates by meeting certain quality benchmarks.

What could this look like if DHCS sets rates sufficiently higher than current rates?

DHCS Approved Rate for Los Angeles County (SAPC)

SAPC Will Retain a Share to Cover Administration and Quality Assurance Costs

SAPC Anticipates Retaining a Share for Other Needs such as Incentives

SAPC shares rates with providers for all levels of care and in consideration of any differential rates by population etc. if determined

<u>All</u> providers receive reimbursement based on the volume of approved services delivered

<u>Only</u> providers who meet quality goals receive supplemental incentive payments

BH Payment Reform – Key Changes (cont'd)

2. No more cost-based reimbursement

- Under the current DMC-ODS reimbursement model, providers reconcile with the county at the lesser of either their costs or charges (aka: State approved claims in the State Reconciliation Report). This means that providers cannot currently be reimbursed above their allowable costs.
- By moving away from cost-based reimbursement under BH payment reform, this cap on revenue will be removed and providers will be able to keep revenue above their costs and reinvest it in their organizations to expand and/or improve services (e.g., pay current staff more, hire more staff, improve clinic/facility).
  - This is a key benefit and opportunity with payment reform for providers.
  - There are other benefits to counties with the move away from cost-based reimbursement that required Certified Public Expenditures (CPE) and toward Intergovernmental Transfers (IGT).
  - With IGTs the State can pay counties timelier, and counties will not need to rely on a cost settlement process with the State that has historically been delayed 6-7 years.

BH Payment Reform – Key Changes (cont'd)

2. No more cost-based reimbursement

- The Opportunity and The Risk
  - Though the sunsetting of cost reconciliation presents an opportunity for providers, it also will require closer tracking of expenditures and revenues.
  - Under the FFS model, providers will receive a rate that will be considered final payment. No other costs will be reimbursed via a final settlement.
  - If the rate or revenue do not support operational costs, the provider stands to incur deficits which may impact organizational viability.

FFS = Need for Active Fiscal Monitoring by Providers

BH Payment Reform – Key Changes (cont'd)

3. New billing codes and processes

- We are currently using HCPCS Level II codes.
- To get into compliance with federal requirements, DHCS is using BH payment reform to move counties to HCPCS Level I and CPT codes → new billing codes and processes.
  - SAPC is crosswalking the old to new billing codes and making necessary changes in Sage for primary Sage users. Secondary Sage users will need to revise their systems in accordance with these new billing codes.
  - ProviderConnect is unable to accommodate this new coding and so the payment reform transition will require SAPC transitioning to the next iteration of ProviderConnect → ProviderConnectNX.
  - By necessity, there will be changes to both the billing and authorization process.
- SAPC will be convening meetings to operationalize this transition in the Fall of 2022.
- Training both SAPC and provider staff will be necessary during this change management process for the new billing codes.

Key Changes to Billing Codes

Current Billing Procedure	Key Changes Coming with Payment Reform
• Basic billing structure	• More detailed billing structure
• Billing primarily using HCPCS codes	• SUD services will continue to be billed under HCPCS • However, CPT codes will be added to allow for more specific billing for LPHA and LP/PA/NP services
• Little differentiation for services between different disciplines	• Additional modifiers will specify types of services specific to HCPCS and CPT codes • Generally, CPT codes use only numbers for modifiers
• Minutes or units for group billing are allowed	All services must be billed in Units only and whole numbers (no fractional units)

New Coding Examples

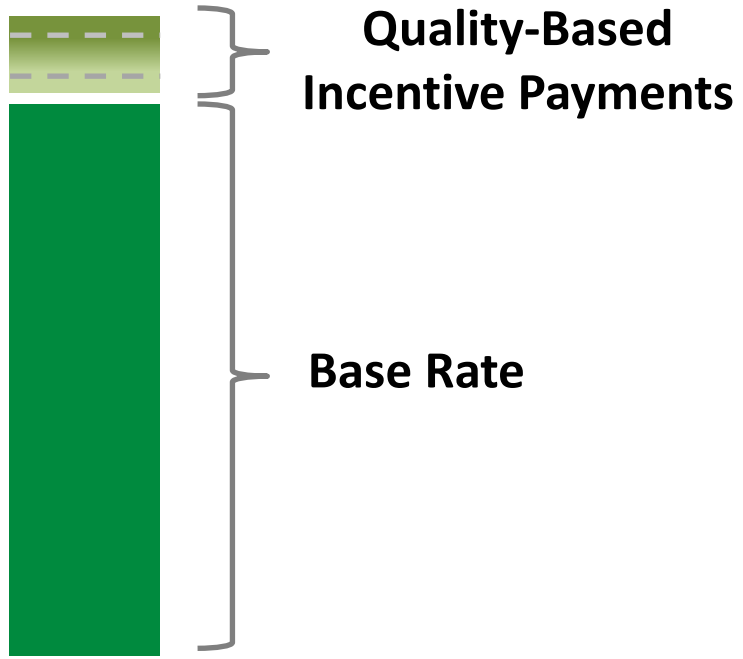
Old HCPS Level II Code	New CPT Code	Applicable Practitioners
H2010 Medication Services	99203 (example) 30-44 min Evaluation & Management	Physician, Physician Assistant, Advanced Practice Nurse
D0001 Discharge Services	90889 (Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries)	LPHAs

BH Payment Reform – How It Impacts SUD Providers

- **Impacts of moving from cost-based reimbursement to fee-for-service (FFS)**
  - Providers will not be able to rely on their costs being covered on a guaranteed basis and instead will need to track their costs carefully to ensure that the revenue generated from their FFS rates can at least cover their costs in order to avoid financial losses.
  - **KEY OPPORTUNITY**: In return for this "risk," payment reform allows revenue generated ABOVE provider costs to be reinvested in your organization to expand and/or improve services (e.g., pay current staff more, hire more staff, improve clinic/facility), which would not be possible without moving away from costs.
  - Cost Reporting
    - While cost reporting in its current form will be sunset with payment reform, for the first several years of payment reform implementation SAPC will be collecting a significantly streamlined form of fiscal reporting that will provide sufficient information to help SAPC inform the State's rate development and inform the transition from cost-based to FFS reimbursement, and ultimately value-based reimbursement.

BH Payment Reform – How It Impacts SUD Providers (cont'd)

- **Eventual transition to value-based reimbursement**
  - In the future, providers will have further opportunity to draw down additional revenue beyond their base rates set by the County (originating from the State rates) through incentive payments based on quality benchmarks that are TBD with future transitions to value-based reimbursement.
  - Based on SAPC's experience with under-utilized incentive payments under DMC-ODS, providers with processes in place to ensure tighter organizational alignment between provider leadership and their clinical staff will be better positioned to benefit from future incentive payments.
  - The shift to FFS and eventually value-based reimbursement will advantage provider agencies with strengths in <u>both</u> business and clinical operations → being strong in just one of these areas will be insufficient.



BH Payment Reform – Timeline

- Target launch date of payment reform and new coding changes is July 2023, but given the technical changes needed within Sage that are not completely under SAPC's control, SAPC is exploring contingency plans for a delayed launch with the State.
- SAPC will be aiming to offer quality-based incentive payments and move to value-based reimbursement as soon as possible following the implementation of payment reform, but this will likely not occur concurrently with implementation.

Overall, the benefits of BH payment reform certainly outweigh the drawbacks. But SAPC also anticipates short-term challenges for likely several years as the amount of change management with the change in billing codes and move away from cost-based to FFS reimbursement is significant and will require an adjustment period.

What SUD Providers Can Be Doing to Prepare for Payment Reform

- **Preparing for transition to FFS reimbursement**
  - Become experts in the costs required to operate & the revenue your services generate – these are two critical data points you will need to track closely to thrive in a FFS environment.
  - Costs and revenue are also the variables that are most under your agency's control to modify to ensure financial sustainability.
    - Identify and address gaps/opportunities leading to financial leakage (insufficient clients, insufficient staff to see clients, high denial rates, etc.) to optimize revenue opportunities.
    - Analyze your costs to ensure they are necessary and appropriate. However, it is important to realize that cost cutting that results in decreased revenue generation may not ultimately support financial sustainability.
- **Preparing for the future transition to value-based reimbursement**
  - Establish processes to optimize organizational alignment and execution – if there are incentive payments for quality metric "X" and provider leadership would like to draw down that incentive payment, what would need to happen in your organization to actually operationalize that desire?
  - Identify ways to optimize outcomes now, before value-based reimbursement is implemented, to best prepare for this goal in the future (leveraging MAT, case management, addressing housing and other social determinants of health, etc.).

CalAIM & Beyond – What's Next for LA County's Specialty SUD System?

- Behavioral Health Administrative Integration
- Ongoing Shift Toward Managed Care Organizations
- SUD Workforce Issues
- Housing & the SUD System
- Challenges & Opportunities

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- **DHCS has set a 2027+ deadline for BH Admin Integration, which focuses on streamlining MH and SUD administrative functions by creating a single State/County contract for specialty MH and SUD services.**
  - Other areas of administrative streamlining: call center, electronic health record (EHR) management, screening/assessment processes, beneficiary informing materials, quality improvement activities, data sharing, etc.
- **The single contract between LA County DMH and SAPC and DHCS will not substantively change operations or services for providers, but will alter contract coordination across SAPC and DMH.**
- **Foundational Principles of BH Admin Integration**
  - Meaningful BH care integration will require more than administrative integration and a dedicated focus on how administrative integration can be translated into on-the-ground BH care integration.
  - Specialty SUD system must be strengthened by BH Admin Integration for it to be effective and achieve true BH care integration.
- **Toward these aims, SAPC and DMH are working together closely to ensure meaningful administrative changes that strengthen and better integrate the MH and SUD system.**

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- **Nationwide, nearly 70% of Medicaid beneficiaries are enrolled in managed care plans and there is a growing push to carve SUD and MH services into managed care organization (MCO) contracts.***
  - California is clearly following this trend through CalAIM and other State-level efforts.
- **It will be increasingly important for specialty SUD systems to position ourselves in a way that adds value to MCOs**:
  - Optimizing engagement of the 95% and those who we need to be serving but who are not presently interested in SUD services
  - Enhancing SUD outcomes (MAT and medications for withdrawal, case management)
  - Increasing comfort and capabilities with serving co-occurring populations in the SUD system
  - Care coordination across health conditions and systems to contribute to "whole person care"
  - Meaningful exchange of patient care info with other providers, in particular primary care
- **MCOs are typically not experts in BH care, so specialty SUD systems will need to be vocal and active in shaping this trend to ensure SUD needs are prioritized**

***Source**: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

CalAIM & Beyond – What's Next for LA County's Specialty SUD System? (cont'd)

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- **SUD Workforce Issues**
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- **LA County (SAPC) sponsored AB 2473 and CAADPE sponsored AB 1860 – both bills were signed by the Governor and represent significant wins for the specialty SUD system by focusing on needed SUD workforce reforms.**
  - **AB 2473** – Enhances the SUD counselor workforce by raising the minimum standards for registered SUD counselors and ensuring both registered and certified SUD counselors are trained on necessary topics of modern SUD systems.
  - **AB 1860** – Strengthens the BH workforce by making it easier for supervised graduate student interns in psychology, social work, MFT, or counseling to work in SUD settings without needing to get registered with an SUD counselor certifying organization.
- **SUD workforce trends/needs**
  - Serving clients with increasingly complex MH and physical health issues
  - MAT and medical withdrawal management remain under-utilized opportunities to optimize outcomes → requires medical personnel
  - Diversification of the SUD workforce – more medical practitioners and licensed clinicians
  - Continuing to grow SUD counselors both in number and quality of training
  - Integrating peers into workforce in supplementary ways
- **Payment reform rates and the ability for SUD providers to manage the business aspects of this shift to FFS reimbursement will be essential to support needed workforce priorities.**

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- **SUDs and homelessness are inextricably associated -** ~20-25% of clients in the specialty SUD treatment system report unstable housing and 26% of people experiencing homelessness that were surveyed report having an SUD.
- **SAPC is engaged with housing partners to explore a more prioritized focus on ensuring the housing continuum (**shelters, interim, permanent supportive, etc) is able to **meet the unique needs of their SUD participants** that may require a different approach than Housing First models or a more nuanced approach within Housing First models.
    - This would likely require distinguishing between a lapse and relapse.
- **SAPC is supportive of expanding field-based SUD services in housing settings and has worked through initial concerns from DHCS.**

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- **Challenges & Opportunities**

- **Reaching the 95%**
  - Focusing not just on targeting and improving services for those who we serve, but those who we need to be serving as well.
  - Accepting clients at different points of recovery rather than having agency policies that require abstinence before someone can receive services will be increasing important.
- **Better Engaging Youth**
  - What can we be doing differently to engage youth (leveraging early intervention, technology, etc.)?
- **Role of Specialty SUD Systems in the Broader Health System**
  - Previously discussed in the "Ongoing Shift Toward MCO" section above.

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- **Challenges & Opportunities** (cont'd)

- **Legislative Opportunities**
  - SUD legislative priorities are unlikely to be advanced by entities other than the SUD system itself – need to identify priorities and move on them.
  - Legislative success → Focus and compromise.
- **Change Management**
  - As discussed in years past, the specialty SUD system must catch up with physical and MH systems and the constant change we have endured since DMC-ODS is the manifestation of this reality.
  - Entities with strong change management will fare best in the years to come.
    - Significant turnover in leaders from DHCS to counties to providers since the pandemic → need to brace for challenges but try to enjoy the journey!

Discussion

Visit RecoverLA.org on your smart phone or tablet to learn more about SUD services and resources, including a mobile friendly version of the provider directory and an easy way to connect to our Substance Abuse Service Helpline at 1-844-804-7500!