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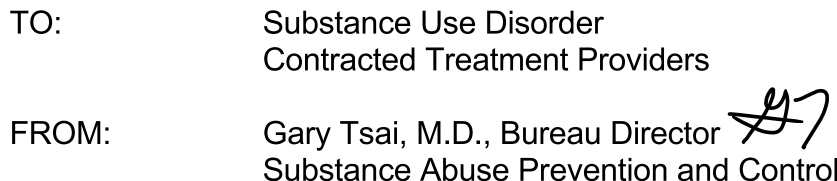

TO: Substance Use Disorder
Contracted Treatment Providers

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

SUBJECT: **FISCAL YEAR 2024-2025 RATES AND PAYMENT POLICY UPDATES**

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative expands on the opportunities created in 2017 when the Los Angeles County Department of Public Health, Bureau of Substance Abuse Prevention and Control (DPH-SAPC) launched the California Department of Health Care Services' (DHCS) Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. A key component and opportunity under CalAIM is behavioral health payment reform to move reimbursement for substance use disorder (SUD) treatment and related services from a cost basis toward a more value-based reimbursement model.

DPH-SAPC is issuing this bulletin under the authority of the Los Angeles County Board of Supervisors and as described in paragraph 3.A., which states, "Contractor shall adhere to any and all Provider Network Bulletins as issued by DPH-SAPC from time to time throughout the term of this Contract, available at the following link: http://publichealth.lacounty.gov/sapc/NetworkProviders/Regulations.htm."

There are several significant CalAIM-related changes that will impact how providers submit Drug Medi-Cal (DMC) treatment and related service claims and receive reimbursement. DPH-SAPC has conducted discussions with contracted providers on these changes and will continue to provide support and technical assistance during this transition.

The Fiscal Year (FY) 2024-25 changes include, but are not limited to:

- A 3.08% increase from FY 2023-2024 rates for most levels of care, except for inpatient withdrawal management levels of care, which contain a 3.18% increase from FY 2023-24 rates.
- An updated set of optional Capacity Building and Incentive fund opportunities.
- Adjusted tier-level assignments for agencies that moved up or down in tier level.
- Rates for an expanded set of providers, including Licensed Psychiatric Technicians, Licensed Vocational Nurses, Medical Assistants, and Occupational Therapists.
- Inclusion of Current Procedural Terminology (CPT) along with Healthcare Common Procedure Coding System (HCPCS) Level II codes.

This DPH-SAPC bulletin, effective July 1, 2024, outlines the implementation of the new rates under payment reform and includes other important payment-related information.

FISCAL YEAR 2024-2025 RATES

In accordance with Paragraph 6(E), "Invoices and Payments" of your contract, "For DMC-ODS services, payments shall be made in accordance with the rates as described in the most current version of the Rate Matrix available at the following link: http://publichealth.lacounty.gov/sapc/NetworkProviders/Regulations.htm."

The Rate Matrix will be effective July 1, 2024, after DPH-SAPC has reviewed and analyzed all DHCS bundled rate categories; stratified rates by tier, American Society of Addiction Medicine (ASAM) level of care, and practitioner type (outpatient only); and considered other programmatic, clinical, and operational needs to ensure an effective and fiscally sustainable specialty SUD treatment system.

DHCS Bundled Rate Categories	Included Levels of Care
Inpatient Withdrawal Management (WM)	ASAM 3.7-WM ASAM 4-WM
Residential	ASAM 3.1 ASAM 3.3 ASAM 3.5 ASAM 3.2-WM
Outpatient	ASAM 0.5 ASAM 1.0 ASAM 2.1 ASAM 1-WM ASAM 2-WM
Opioid Treatment Program	OTP

TIERED RATES AND TIER ASSIGNMENT METHODOLOGY

DPH-SAPC established a tiered rate system for specific levels of care as outlined in the table below. The tiered rate system establishes higher rates for providers that offer a more expansive continuum of services and accounts for higher associated costs and incentivizes the expansion of services within the organization to facilitate improved and more coordinated care.

Tiered Rate	Non-Tiered Rate
• Outpatient (ASAM 1.0) • Intensive Outpatient (ASAM 2.1) • Outpatient WM (ASAM 1-WM, 2-WM) • Residential (ASAM 3.1, 3.3, 3.5) and Residential Withdrawal Management (3.2-WM) • Care Coordination • Recovery Services	• Inpatient WM (3.7-WM, 4-WM) • Opioid Treatment Programs • Recovery Bridge Housing • Recovery Housing

Providers were assigned to one of three tiers based on their contracted and utilized levels of care according to FY 2023-24 billing activity, where the Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF) counted as a level of care to reflect its value ensuring delivery of quality care and incentivize expanded network participation.

The utilization of providers' contracted levels of care is based on consistent and ongoing use based on billing activity throughout the fiscal year, as verified by Sage billing activity. Providers must bill monthly via Sage to receive credit for utilized levels of care. DPH-SAPC staff will monitor providers' billing activity and determine their rate tier based on billing activity from July through March in advance of the next fiscal year's determination. Providers must also maintain their accreditation to continue to receive this credit in their tier determination. A lapse of accreditation may result in the reassessment and determination of a provider's assigned tier. Please submit new, renewed, or revised accreditations to your assigned Contract Program Auditor.

DPH-SAPC will reassess a provider's contracted and utilized levels of care and accreditation status as part of the end-of-year activities. Additional analysis may include a review of the provider's fiscal reports, which will be conducted at the end of the third quarter of the fiscal year. This is why it is essential that providers submit treatment claims timely and accurately, including resolving and resubmitting any denied claims, as appropriate. Providers are reminded to contact the Sage Helpdesk with any billing issues.

Providers may contact DPH-SAPC Financial Services Division at SAPC-Finance@ph.lacounty.gov for more information or questions on their assigned tier.

Below is the list of contracted levels of care that were considered in this analysis and the tier methodology:

Tier Levels of Care Consideration	Tier Methodology
• ASAM 1.0: Outpatient • ASAM 2.1: Intensive Outpatient • ASAM 1-WM: Outpatient WM • ASAM 3.1: Residential • ASAM 3.3: Residential • ASAM 3.5: Residential • ASAM 3.2-WM: Residential WM • ASAM 3.7-WM: Inpatient WM • ASAM 4-WM: Inpatient WM • Opioid Treatment Program • Recovery Bridge Housing • Accreditation by Joint Commission or CARF	**Tier 1** 1 or 2 Levels of Care **Tier 2** 3, 4, or 5 Levels of Care **Tier 3** 6 or more Levels of Care

REIMBURSEMENT AND CLAIMING CHANGES

CalAIM's Payment Reform provisions include several changes that impact how providers submit claims and are reimbursed. The following changes are effective July 1, 2024:

Fee-for-Service Reimbursement

Beginning July 1, 2023, and in accordance with the payment reform provisions of CalAIM, DMC treatment services are reimbursed via a fee-for-service (FFS) structure. This reimbursement approach combined with the transition away from cost-based reimbursement allows providers to reinvest excess funds at the organization's discretion while still adhering to the County's Auditor Controller's Handbook. This structure also significantly streamlines Fiscal Reporting requirements and excludes subsequent cost reconciliation.

While the new reimbursement model creates efficiencies and opportunities for providers to invest in programs, it also requires that providers have systems in place to ensure that revenue is meeting organizational expenditures. Once a claim has been approved and reimbursed, providers must ensure that the revenue is sufficient to cover the cost associated with providing that unit of service. No additional funding will be provided for services rendered.

Fiscal Reporting

In accordance with DMC-ODS guidelines, DPH-SAPC will no longer use DHCS's Cost Report Template for DMC-reimbursable services. For the initial years after the launch of CalAIM, DPH-SAPC will implement a significantly streamlined Fiscal Reporting process to collect financial information at the organizational level as part of the ongoing effort to ensure rates are appropriately supporting providers and enabling the transition to value-based care. This information will also inform the determination of Rate Tiers if it is continued in future

years. Additionally, DPH-SAPC will continue to conduct fiscal compliance audits/reviews via its partnership with the Los Angeles County Department of the Auditor-Controller.

Practitioner Rates

For outpatient levels of care (e.g., ASAM 1.0, 2.1, 1-WM, 2-WM) reimbursement rates are based on the practitioner level delivering the treatment services. This enables providers to further diversify their direct service workforce to include more Licensed Practitioners of the Healing Arts (LPHA), expand onsite service options such as Medications for Addiction Treatment (MAT) and family therapy, and compensate them at a higher level to support competitive salaries and benefits. Differential rates for registered versus certified counselors also acknowledge that increased education and training should be supported with enhanced rates and increased compensation packages (see *Capacity Building and Incentives* section to learn more about funding to support SUD Counselor staff costs to become certified).

To fully leverage and benefit from this opportunity, providers need to develop and implement billing processes to ensure that treatment services are being billed under the accurate and actual practitioner level(s). Services MUST be billed in accordance with the staff that provided the services (e.g., services provided by a registered counselor can only be billed under the registered counseling rates) and staff must be delivering services in accordance with all applicable local, state, and federal rules and requirements, including scope of practice requirements. Intentional and/or accidental inappropriate billings may result in non-compliance and contractual actions.

Residential Rates

DHCS intends to re-bundle residential treatment rates by FY 2026-27 which would end the ability to submit separate claims for care coordination, medication services, peer services, and recovery services in addition to the day rate. Therefore, it is imperative that residential providers immediately and consistently submit appropriate claims for these services so that the cost to deliver this care can be incorporated into DHCS' calculations when determining revised DMC rates. If DHCS bundles residential rates as currently indicated, providers will no longer be able to submit separate care coordination, medication services, peer services, and recovery services claims, and SAPC will not establish reimbursement codes to be paid outside of the DMC system. For future bundled residential rates to benefit from this transition period requires most, if not all, SAPC providers to take action and bill these claims separately, and in addition to, the day rate. Insufficient participation likely will not translate to an appreciable increase in rates as a result.

Important Note: Throughout FY 2024-25, SAPC will continue to include a billable rate associated with the code H2010S which can be used by contracted providers to claim billable time that eligible staff spend conducting medication handling and safeguarding in residential settings. This H2010S code will be a time-limited transitional billing mechanism for medication handling and safeguarding in residential settings that will end after June 30, 2025. During FY 2024-25, providers should prepare to transition away

from staffing models reliant upon fee-for-service revenue using the H2010S billing code for residential medication handling and safeguarding services and instead utilize the Medi-Cal reimbursable rates available for medication related services delivered in residential settings of care. Effective July 1, 2025, provider agencies will no longer have a H2010S code available to claim for time staff spend conducting medication handling and safeguarding in residential settings.

Inclusive Rates

A key goal of CalAIM is to streamline processes and create efficiencies. As such, the following activities that were previously billed separately are now bundled within the service rates:

- *Travel Time*
- *Documentation*

While these activities are no longer permitted to be billed separately (e.g., cannot add associated time to the direct service claim), providers are compensated for associated costs within each service delivered. For example, even though each service is not delivered in a field-based location, travel costs / time is incorporated within each outpatient service rate claimed.

Addition of Current Procedural Terminology (CPT) Codes

Under the provisions of CalAIM, the DMC claiming process will include Current Procedural Terminology (CPT) along with Healthcare Common Procedure Coding System (HCPCS) Level II codes. CPT codes will be used to bill for services offered by LPHA/LPHA-eligible and HCPCS codes will primarily be used for services conducted by registered and certified SUD counselors. The inclusion of CPT codes reflects the increased role that licensed professional staff can offer in SUD treatment. Permitted CPT and HCPCS codes are included in the Rates Matrix.

Changes to Service Codes and the Rates and Standards Matrix

DHCS has implemented changes to the service codes effective July 1, 2024. These changes have been updated on DPH-SAPC's Rates and Standards Matrix. A summary of changes is included in the attachment titled, "FY 2024-25 Service Codes & Rates and Standards Matrix Change Update".

Medicare Enrollment

Federal guidelines mandate that providers first bill Medicare and/or Medicaid for patients enrolled in those benefits. As such, providers must enroll in the federal Medicare program to be in compliance with this policy. Medicare enrollment information is available at the following site: Medicare Enrollment.

CAPACITY BUILDING AND INCENTIVE INITIATIVES

As part of its Payment Reform strategy, and building on Year 1 of Payment Reform, DPH-SAPC will continue to offer its providers additional resources to fully leverage the

opportunities afforded by CalAIM and to help make the necessary organizational changes to better implement new guidelines and program requirements via 1) Capacity Building and 2) Incentives. Both efforts are designed to offer support at both providers at the staff and organizational level.

What is Capacity Building?

Funds that DPH-SAPC pays a treatment provider either in advance to ensure start-up funds to do something or after the fact to compensate a treatment provider for completing something. Capacity building is designed to help prepare providers to meet select metrics and maximize a supplemental incentive payment. Providers need to verify expenditures or submit a deliverable for full payment.

What are Incentives?

Funds that DPH-SAPC pays a treatment provider after achieving a performance metric associated with the incentive payment. Providers need to verify completion and submit relevant data for full payment. Providers keep all funds if the metric is met and do not submit expenditure verification. The funds can be used to reinvest in the program as needed, including to support activities associated with the metric.

DPH-SAPC's Payment Reform Webpage includes more information on Capacity Building and Incentives opportunities for FY 2023-24 and FY 2024-25.

Capacity Building

DPH-SAPC is offering optional capacity building funds to support providers with development in the following areas:

Workforce Development: Recruitment, Retention, and Training

DMC-ODS and CalAIM initiatives transformed the specialty SUD service system for Medi-Cal clients and continue to increase expectations for the workforce in the form of higher clinical, documentation, and outcome standards. Additionally, providers may bill higher rates based on services conducted by higher credentialed staff under payment reform. SB 525 has also changed salary expectations across the health service landscape and elevated the need for SUD providers to stay competitive with other health care agencies. These funds are designed to give providers a competitive advantage in developing, recruiting, and retaining SUD treatment staff. Further, they address persistent challenges and ensure that staff are prepared to work with an increasingly complex patient population and a specialty SUD treatment environment where patient outcomes will be central to future reimbursement models.

Access to Care: Reaching the 95%

A shared priority for all providers and DPH-SAPC is to ensure that there are active and ongoing outreach and engagement efforts to reach people who need SUD treatment but either don't think they need it or don't want it. The "Access to Care: Reaching the 95%" category ensures that the network is designed for both those individuals actively seeking treatment and those who are open to services but are not ready or willing to be

abstinent. This is accomplished by creating internal policies that support lower barrier care and formal plans that describe community and external outreach and engagement.

Fiscal, Business, and Operational Efficiency

A fundamental change under CalAIM is the elimination of cost reconciliation and the shift to fee-for-service reimbursement. These changes make it essential that providers have robust and accurate financial systems and processes to track revenue to achieve two goals: 1) Ensure that services provided cover expenditures; and 2) Identify available funds to reinvest in the organization. Additionally, data and quality improvement systems to track progress in patient outcomes will be critical for future reimbursement models.

Incentives

Payment reform in July 2023 served as the first step toward moving away from a volume-based and towards a value-based reimbursement structure for specialty SUD systems. This required defining performance metrics to validate whether provider agencies deliver, and patients receive, outcome-focused services that translate to value-based care. In Year 2 of Payment Reform, DPH-SAPC built upon FY 2023-24 incentive metrics package and continue to move the SUD system toward this new model.

The five key categories of focus under DPH-SAPC's FY 2024-25 incentive structure include:

1. Workforce Development: Recruitment, Retention, and Training
2. Access to Care: Reaching the 95%
3. Medications for Addiction Treatment (MAT)
4. Optimizing Care Coordination
5. Enhancing Data Reporting

Billing for Capacity Building & Incentives

Both the Capacity Building and Incentive payments are structured according to a provider's assigned Rate Tier. Providers interested in participating in Capacity Building and/or Incentive Metrics Initiatives need to submit the appropriate attestation and invoice for the effort(s) being claimed.

DPH-SAPC's Payment Reform Webpage will include documents detailing the FY 2024-25 Capacity Building and Incentives package as well as required invoice templates.

Budgeting for Capacity Building and Incentive

Providers should include the expected Capacity Building and Incentive funding in their FY 2024-25 DMC Contract Budget to ensure proper tracking and utilization. Providers must review the relevant Capacity Building and Incentive materials and determine which activity to participate in and notify DPH-SAPC accordingly.

Based on that determination they should then budget that amount and enter it under the "Services and Supplies" section of the contract budget. The table below provides an

estimated maximum allocation (if all funds were drawn down) for both Capacity Building and Incentives based on the provider's assigned tier.

Provider Maximum with Full Participation	Tier 1 Provider	Tier 2 Provider	Tier 3 Provider
Capacity Building Total	$179,000	$261,000	$343,000
Incentive Total	$240,000	$360,000	$480,000
Capacity Building & Incentive Subtotal	**$419,000**	**$621,000**	**$823,000**

ADDITIONAL BENEFITS UNDER THE DMC TREATMENT CONTRACT

Reimbursement under the DMC-ODS Contract expands to include an invoice process, in addition to the Rates Matrix, for the following select services under the treatment services benefit:

- Capacity Building and Incentives
- Contingency Management (Recovery Incentive Program)
- Select Youth and Pregnant / Parenting Women Services

For information on which invoice to use, or more information on these services, see relevant sections in this Bulletin or other corresponding bulletins which are available at the SAPC website:
http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm#bulletins

RESOURCES

The following resources provider additional information and guidance:

- The SAPC Provider Manual
- Sage 837P Companion Guide
- Sage 837I Companion Guide
- Behavioral Health Information Notice No. 23-001

EFFECTIVE PERIOD

This guidance will be effective July 1, 2024 through June 30, 2025, unless otherwise revised.

ADDITIONAL INFORMATION

For additional questions or requests, please contact your assigned Contract Program Auditor.

Attachments

GT:dd