COUNTY OF LOS ANGELES Public Health

START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

INVESTING IN THE FUTURE OF SUBSTANCE USE DISORDER SERVICES:

The Intersection Between Higher Rates and Higher Expectations

December 15, 2016

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control (SAPC)

START-ODS

CONTINUED SUD SYSTEM TRANSFORMATION WITHIN CHANGING POLITICAL CONDITIONS:

START-ODS Advances as Planned

BUILDING A MODERN SUD SYSTEM OF CARE:

Improved Care Requires Improved Rates

MOVING TOWARDS PARITY
WITH THE MENTAL AND PHYSICAL HEALTH SYSTEMS

Rates need to support the real cost of providing quality SUD care that improve outcomes for our patients. This includes the ability of the County and its network providers to invest in the following:

- Hiring, training and retaining a qualified workforce
- Implementing evidence-based practices with fidelity that are relevant for the target population
- Enhancing operational, clinical and technological procedures and infrastructure
- Innovations to improve access to care and health outcomes

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THE RATES METHODOLOGY AND THE NEXUS WITH PATIENT CARE

WHAT INFORMED THE PROCESS TO DEVELOP BUNDLED RATES

- Usual, customary and reasonable payment rates, including comparable mental health services
- Projected DMC-eligible population and admissions
- Projected utilization by level of care (LOC), including care transitions
- Projected utilization for each allowable service and length of stay
- Historical claims and cost reports
- Clinical standards and experience

STEP 1 – RATE COMPARISON

- **Usual, Customary and Reasonable (UCR) Rates Analysis:**
  - What does SAPC pay for non-DMC services?
  - What do other jurisdictions around the country pay for SUD services?
  - What does the mental health system pay for similar specialty services?

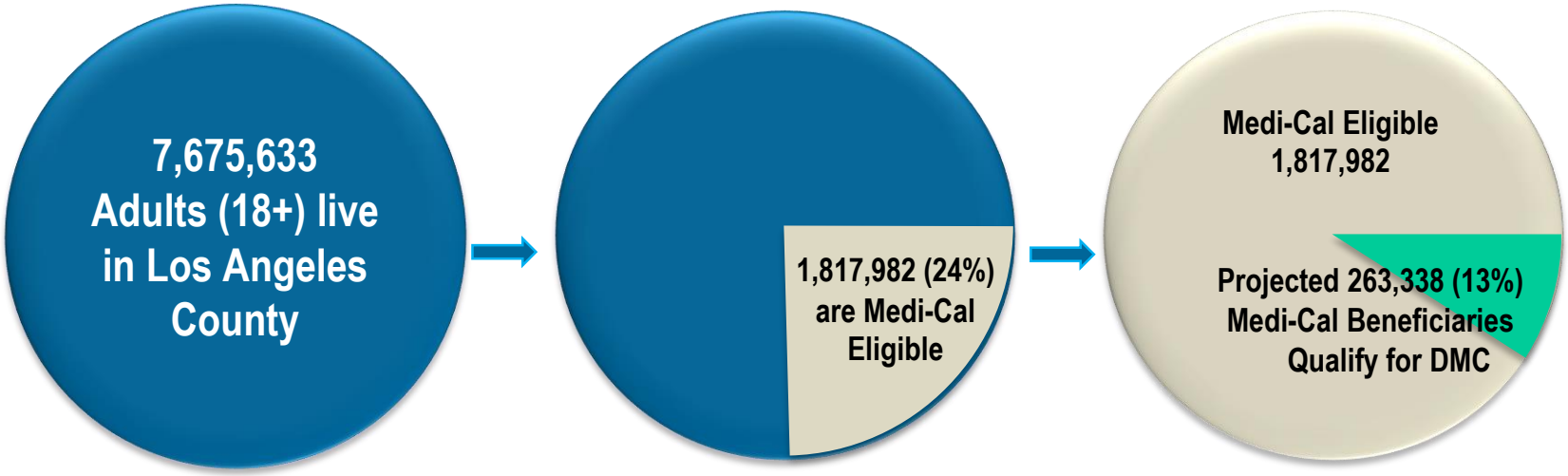
- **Emphasis on Mental Health Rates:**
  - What system do we want to aspire to?
  - What approach will better enable care integration and support partnership?

STEP 2 – UTILIZATION

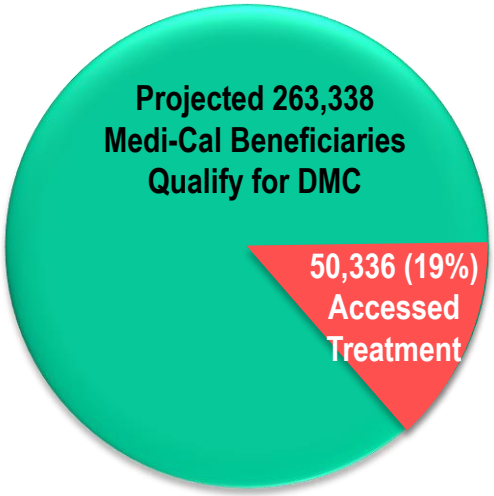
- **Historical Claims and Costs:**
  - What do the past 10 years of LACPRS data tell us about utilization and transitions in care (step-up/step-down)?
  - What does the claims system tell us about utilization?
  - What is learned from provider cost reports?

- **Medi-Cal Expansion and an Expanded DMC Benefit Package:**
  - How many people do we anticipate will enter the system because of expanded eligibility?
  - How many people may need SUD treatment but do not seek it?
  - Will more people seek services because the benefit package will be better?

Need for SUD Services: Adult



Access Gap: Adult



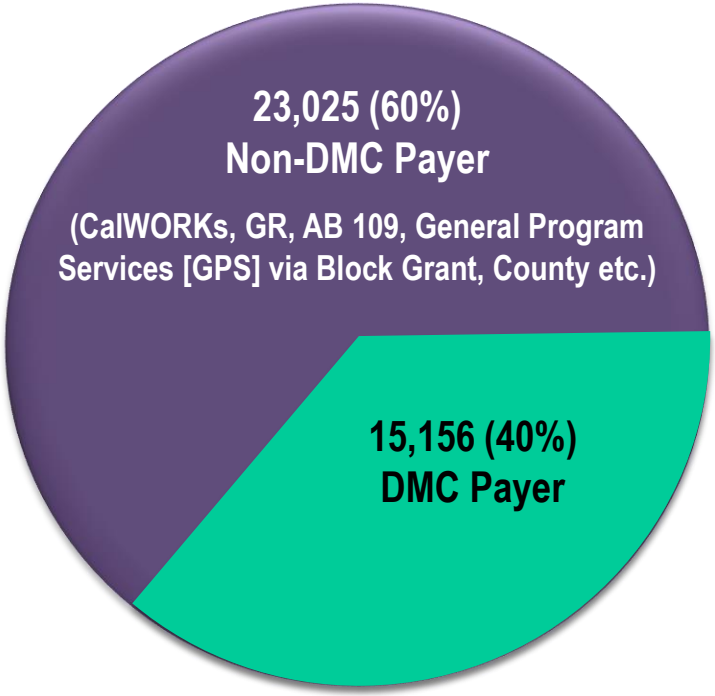
GROWTH POTENTIAL

Approximately 71% of adults in need of SUD treatment do not access services (based on 13% SUD prevalence among adults).

DMC contract amounts can be increased based on need, performance and utilization.

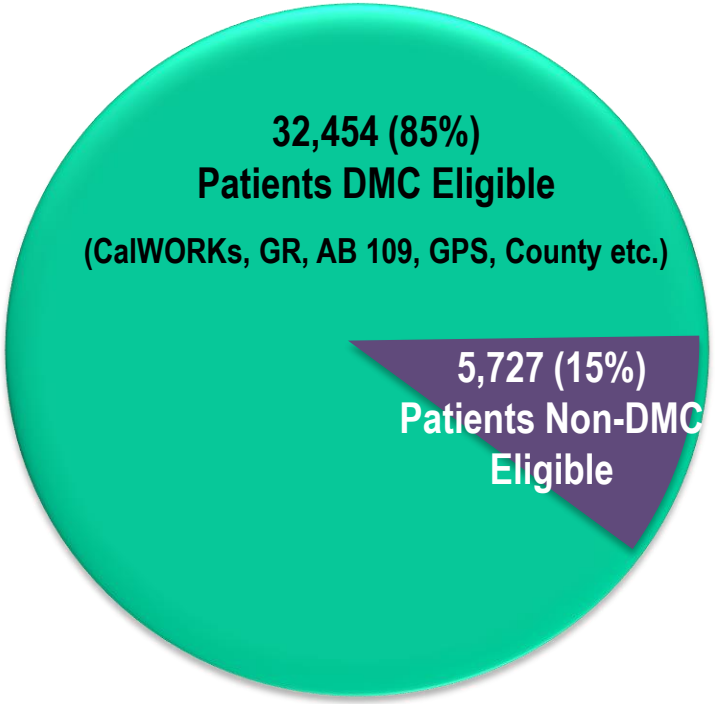
WHO PAID FOR SERVICES?

Unique Adult Clients FY 15-16



WHO WOULD PAY UNDER START-ODS?

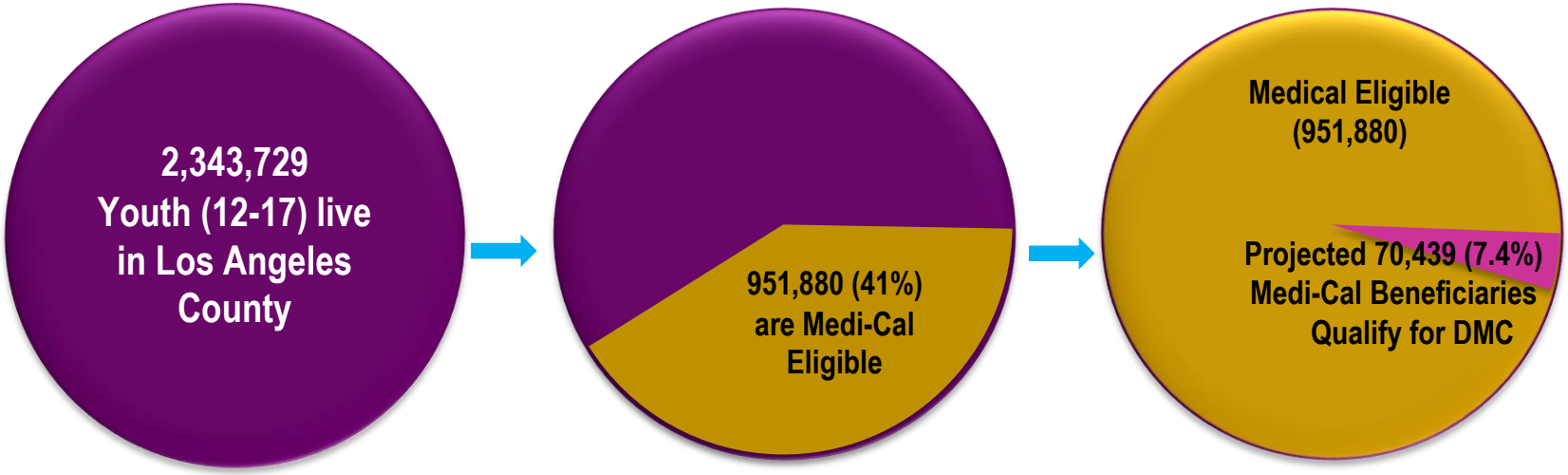
Unique Adult Clients FY 15-16



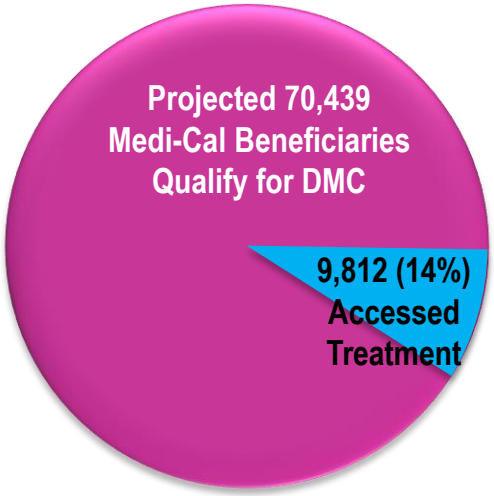
PATIENT LOSS POTENTIAL

If you apply 2016 Medi-Cal expansion eligibility criteria to FY 15-16 adult unique clients, most (85%) adult patients would have been DMC eligible

Need for SUD Services: Youth



Access Gap: Youth



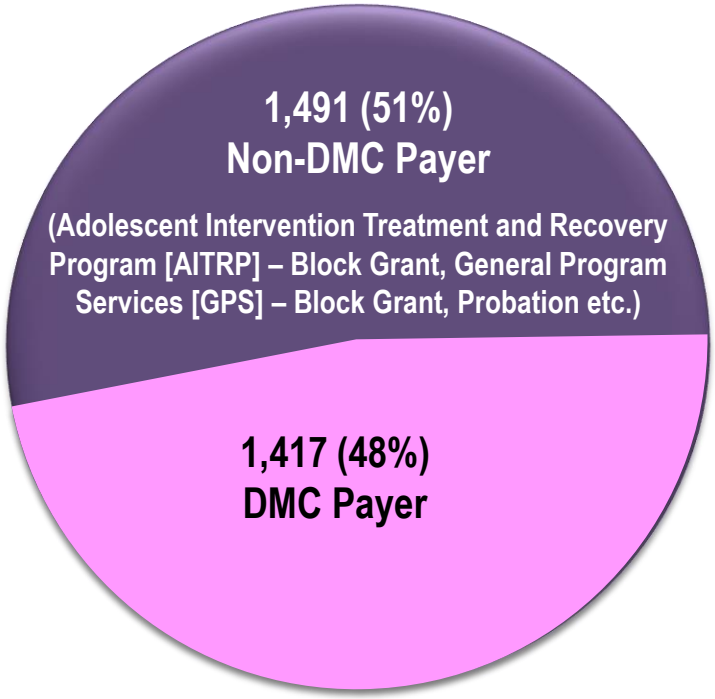
GROWTH POTENTIAL

Approximately 86% of youth in need of SUD treatment do not access services (based on 7.4% SUD prevalence among youth).

DMC contract amounts can be increased based on need, performance and utilization.

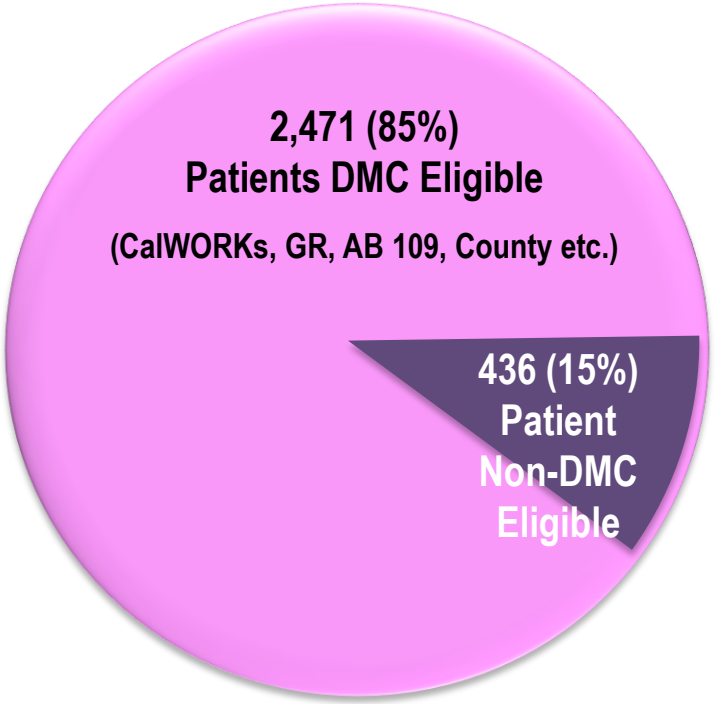
WHO PAID FOR SERVICES?

Youth Unique Clients FY 15-16



WHO WOULD PAY UNDER START-ODS?

Youth Unique Clients FY 15-16



PATIENT LOSS POTENTIAL

If you apply 2016 Medi-Cal expansion eligibility criteria to FY 15-16 youth admissions, most (85%) youth patients would have been DMC eligible.

Eligibility Drives Payment Source

If a individual is Medi-Cal eligible and has a substance use disorder (SUD) diagnosis, he or she must be served at a DMC certified/licensed site.

START-ODS

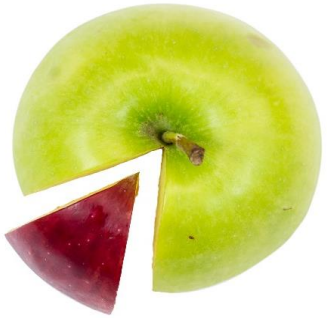
REPURPOSE OTHER SAPC FUNDS

Since DMC will pay for most services for most patients, other funds such as SAPT Block Grant, AB 109, CalWORKS etc. will be repurposed to cover non-DMC reimbursable services in the benefit package, other qualified individuals who are not DMC-eligible, and other essential projects as permitted by the funding source:

- Residential Room and Board Costs
- System Navigators
- Recovery Bridge Housing
- Beneficiary Access Line

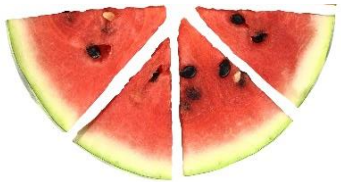
DMC Covers Most Services for Most Patients Beginning July 1, 2017

Multiple Primary Payers

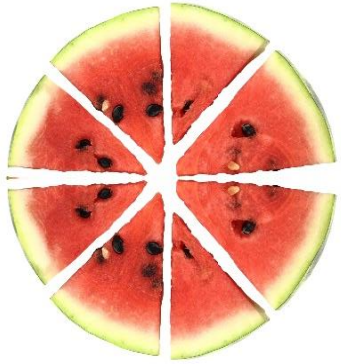


DMC Primary
Unless Patient Ineligible

All SAPC Contractors DMC Certified/Licensed at All SUD Treatment Sites by July 1, 2017



Many SAPC Providers/Sites



All SAPC Providers/Sites

STEP 3 – SERVICES BY LEVEL OF CARE

- **Average Services by Level of Care (LOC):**
  - What services are provided at each LOC?
  - How much of each service would the average patient receive?
  - How long would a patient generally stay at each LOC?

- **Expected Transitions in Care:**
  - What percent of patients will likely step-up to a higher LOC?
  - What percent of patients will likely step-down to a lower LOC?
  - What percent of patients will likely transition directly to recovery support?

PROJECTED TRANSITIONS IN CARE EXAMPLE

Intensive Outpatient (IOP) ASAM 2.1

- 20%
- 95% Residential ASAM 3.5
- 5% Residential ASAM 3.1

30% of intensive outpatient patients are not anticipated to transition to another LOC but all can access recovery support services

- 50% → 100% Outpatient ASAM 1.0

Residential ASAM 3.5

- 0%
- 60%
  - 20% Residential ASAM 3.1
  - 50% Intensive Outpatient ASAM 2.1
  - 30% Outpatient ASAM 1.0

40% of residential patients are not anticipated to transition to another LOC but all can access recovery support services

CASE MANAGEMENT IS EXPECTED TO IMPROVE TRANSITIONS IN CARE

- According to LACPRS currently, patients transitioning to a lower or higher level of care after discharge is relatively low.
- Assuming higher transitions in care (increased utilization) was one factor used to support higher rates.
- Providers will need to use case management services to support and document these improved transitions in care → should improve overall patient outcomes.

STEP 4 – BUNDLING SERVICES TO CREATE RATES

PART A – PROJECT TOTAL PERSONS SERVED:

- Determine historical and projected admissions
- Establish transition rules (step-up and step-down care)
- Establish median length of stay by LOC

STEP 4, PART A DETERMINED THE PROJECTED TOTAL ANNUAL ADMISSIONS, INCLUDING NEW EPISODES AND CARE TRANSITIONS.

STEP 4 – BUNDLING SERVICES TO CREATE RATES

PART B – RATE PER HCPCS CODE*:

- Applied a 1.52 multiplier to non-DMC rate to reflect median disparity between SAPC and mental health rates
- Applied 10% increase to account for the increased costs of building necessary clinical and business capacity to provide enhanced services
- Applied 2.4% inflation factor
- Determined rates are the same for all populations/ages served

STEP 4, PART B BUILT RATES THAT ALLOW THE SUD SYSTEM TO MOVE TOWARD PARITY WITH MENTAL HEALTH AND BUILD A MORE MODERN SUD SYSTEM OF CARE.

*HCPCS – Healthcare Common Procedure Coding System

STEP 4 – BUNDLING SERVICES TO CREATE RATES

PART C – BUNDLE BILLABLE HCPCS CODES BY LOC:

- Determined 15-minute increment rates by LOC
- Determined Day Rates by LOC

STEP 4, PART C DETERMINED THE BUNDLED FEE-FOR-SERVICE RATE PAID BY LEVEL OF CARE.

- **All services (e.g., treatment plan) within a LOC reimbursed in a 15-minute increment will be at the same amount.**
- **All services within a LOC reimbursed at a day rate will be provided under the combined day rate.**

START-ODS

THE NEW DRUG MEDI-CAL RATES FOR FISCAL YEAR 2017-2018

Los Angeles County DMC Rates for Fiscal Year 2017-2018			
ASAM LOC/Service	**Unit of Service (UOS)**	**Interim Rate per UOS**	**Projected Persons Served**
1.0 Outpatient	15-minute (except group which is per session)	$29.63	25,667
2.1 Intensive Outpatient	15-minute (except group which is per session)	$32.01	10,591
3.1 Residential	Day Rate	$145.71 (includes $36.43 for R&B, non-DMC funds)	1,648
3.3 Residential	Day Rate	$187.85 (includes $46.96 for R&B, non-DMC funds)	3,244
3.5 Residential	Day Rate	$166.70 (includes $41.47 for R&B, non-DMC funds)	10,026
1-WM Withdrawal Management	Day Rate	$210.46	1,047
3.2-WM Withdrawal Management	Day Rate	$381.37 (incudes $95.34 for R&B, non-DMC funds)	4,186
Case Management	15-minute	$33.83	24,511
Recovery Support Services	15-minute	$20.89	10,748

OUTPATIENT: DMC This Year → DMC Next Year

County of Los Angeles Public Health

ASSESSMENT – 90 MINUTES

This Year $69.50

Next Year $177.78

CASE MANAGEMENT – 15 MINUTES

This Year $0

Next Year $33.83

INDIVIDUAL COUNSELING – 60 MINUTES

This Year $0

Next Year $118.52

TREATMENT PLAN – 60 MINUTES

This Year $69.50

Next Year $118.52

This Year: 90-Day Episode $798*

Next Year: 90-Day Episode $4,141* (+419%)

FAMILY COUNSELING – 60 MINUTES

This Year $0

Next Year $118.52

GROUP COUNSELING – 60 MINUTES

10 PATIENTS

This Year $183.07

Next Year $296.30

PHYSICIAN EVALUATION – 15 MINUTES

This Year $0

Next Year $29.63

DRUG TESTING – PER UNIT

This Year $0

Next Year $29.63

* This is only an example and does not necessarily represent what will actually be paid for services at this LOC and duration . All services delivered must be based on medical necessity.

OUTPATIENT: Non-DMC This Year → DMC Next Year

County of Los Angeles Public Health

ASSESSMENT – 90 MINUTES

This Year $83.50

Next Year $177.78

CASE MANAGEMENT – 15 MINUTES

This Year $17.41

Next Year $33.83

INDIVIDUAL COUNSELING – 60 MINUTES

This Year $83.60

Next Year $118.52

TREATMENT PLAN – 60 MINUTES

This Year $17.51

Next Year $118.52

This Year: 90-Day Episode $2,478*

Next Year: 90-Day Episode $4,141* (+67%)

FAMILY COUNSELING – 60 MINUTES

This Year $0

Next Year $118.52

GROUP COUNSELING – 60 MINUTES

10 PATIENTS

This Year $208.80

Next Year $296.30

PHYSICIAN EVALUATION – 15 MINUTES

This Year $0

Next Year $29.63

DRUG TESTING – PER UNIT

This Year $20.22

Next Year $29.63

* This is only an example and does not necessarily represent what will actually be paid for services at this LOC and duration. All services delivered must be based on medical necessity.

RESIDENTIAL 3.1 – 3.3 - 3.5: SUD → DMC

County of Los Angeles Public Health

ASSESSMENT

PHYSICIAN EVALUATION

TREATMENT PLAN

DRUG TESTING

GROUP COUNSELING

TRANSPORTATION

INDIVIDUAL COUNSELING

FAMILY COUNSELING

THIS YEAR – SUD CONTRACT

Day Rate $121.93

60-Day Episode with CM: $7457*

NEXT YEAR – DMC CONTRACT

ASAM 3.1 Low Intensity

Day Rate $145.71

60-Day Episode with CM: $9,013* (+21%)

ASAM 3.3 High Intensity (Population Specific)

Day Rate $187.85

60-Day Episode with CM: $11,541* (+55%)

ASAM 3.5 High Intensity (Non-Population Specific)

Day Rate $166.70

60-Day Episode with CM: $10,272* (+38%)

CASE MANAGEMENT

Billed Separately

15 minutes - $33.83

Projected 8 Units/60 Days

* This is only an example and does not necessarily represent what will actually be paid for services at this LOC and duration. All services delivered must be based on medical necessity.

WITHDRAWAL MANAGEMENT 1-WM 3.2 WM: SUD → DMC

County of Los Angeles Public Health

ASSESSMENT

SUB-ACUTE DETOX

AOD SCREENING

CASE MANAGEMENT
Billed Separately
15 minutes - $33.83

THIS YEAR – SUD CONTRACT
WM-1, OUTPATIENT

Day Rate $0
60-Day Episode with CM: $0

NEXT YEAR – DMC CONTRACT
WM-1, OUTPATIENT

Day Rate $210.46
3-Day Episode with CM: $766*

THIS YEAR – SUD CONTRACT
WM-3.2, RESIDENTIAL

Day Rate $343.92 Average
7-Day Episode with CM: $2,477*

NEXT YEAR – DMC CONTRACT
WM-3.2, RESIDENTIAL

Day Rate $381.37 (+13%)
7-Day Episode with CM: $2,804*

* This is only an example and does not necessarily represent what will actually be paid for services at this LOC and duration . All services delivered must be based on medical necessity.

OTHER DMC SERVICES

CASE MANAGEMENT

Available During Treatment
$33.83 (15-minute increment)

RECOVERY SUPPORT

Available Post Treatment
$20.89 (15-minute increment)

START-ODS

MANAGING THE NEW SUD SYSTEM

PROVIDING MEDICALLY NECESSARY AND PATIENT CENTERED CARE

- **The American Society of Addiction Medicine (ASAM) Criteria will drive placement decisions:**
  - What level of care (LOC) best matches the patients needs and preferences?
- **The ASAM-based screening (brief triage assessment) and full assessment will inform what services a patient needs and at what frequency:**
  - How often does the patient need to come to treatment to see results instead of a one-size fits all approach?
  - Would the patient do better with more individual than group sessions?
  - How do you change the service mix based on progress or lack of progress?

SAPC CLINICALLY RELATED EFFORTS

- **QUALITY IMPROVEMENT (QI) AND UTILIZATION MANAGEMENT (UM)**
  - A new QI program with licensed clinicians charged with conducting periodic clinical oversight to ensure services follow a standard of clinical practice consistent with medical necessity, best practice, and ASAM Criteria.
  - A new UM program with licensed clinicians to ensure quality services by monitoring adherence to the guidelines. This includes the preauthorization of residential treatment admissions, among other services that require authorization.

- **INFORMATION TECHNOLOGY**
  - New automated appointment, bed/slot, service authorization systems
  - New electronic health record-like system

SAPC ADMINISTRATIVE EFFORTS

- **CONTRACT MANAGEMENT**
  - Incorporating the QI & UM programs in the monitoring process
  - Updating contracts and monitoring tools
  - Ensuring SAPC providers are DMC certified
  - Ensuring DMC eligible patients are served only in DMC certified/licensed programs

- **FISCAL AND REIMBURSEMENT**
  - New risk assessment and management efforts
  - New reimbursement rates and cost reconciliation procedures

BUDGETS AND END OF YEAR CLOSE-OUT

COST RECONCILIATION: Settle up to, but not to exceed, the rate for services delivered to patients where allowable costs align with SAPC requirements including business and clinical capacity efforts outlined in the DHCS approved Fiscal and Rates Plan. This process takes effect Fiscal Year 2017-2018.

COST SETTLEMENT: Settle up to the substantiated costs of delivering services to patients which may exceed the established rates. This process ends for all contracts June 30, 2017.

START-ODS

SUBSTANTIATING THE HIGHER RATES WITH IMPROVED CARE AND CAPACITY EFFORTS

Achieving Parity with Mental and Physical Health Systems

AND

Establishing a Modern SUD System of Care

To achieve these goals, the County needs to establish sufficiently robust rates to allow for sustainable investments in the necessary clinical and technological infrastructure to advance the SUD system of care; *AND* SAPC and its providers need to evaluate how the system is currently structured and make necessary changes to achieve this new vision for patient care.

ALLOWABLE CAPACITY BUILDING COSTS

Network providers will need to evaluate existing management and staffing structures, as well as clinical and operational procedures, to ensure their ability to meet new clinical, data, fiscal, and quality assurance requirements. Provider-level workforce and clinical enhancements could include:

- Hire medical director(s) for new/expanding DMC agencies and/or redefining the role of the medical director to allow for a transition of select responsibilities to Licensed Practitioners of the Healing Arts (LPHA).
- Hire or train LPHAs to meet the requirement that an LPHA determine medical necessity before initiating DMC-ODS treatment, as well as to provide more complex services, such as family counseling.
- Reconfigure and expand staffing structures to align with the new range and complexity of clinical responsibilities and to provide newly reimbursable services.
- Train staff to implement clinical best practices (e.g. motivational interviewing and cognitive behavioral therapy), American Society of Addiction Medicine (ASAM) based LOC placements, and standardized assessment/treatment plan formats.
- Implement a broader biopsychosocial treatment model, especially when newly required services (e.g., MAT) and standards (e.g., practitioner expertise/level) may be in conflict with existing practice.

ALLOWABLE CAPACITY BUILDING COSTS

While the County, in collaboration with stakeholders, will define some of these new clinical and staffing expectations, network providers will need to determine what makes the most business sense when considering expectations to deliver services that help individuals achieve long-term positive health outcomes. There are several implications for providers' business processes:

- Upgrade technology to enhance capabilities to interface with County automated systems and implement an electronic health record (EHR) or adopt SAPC's managed care information system (MCIS).
- Hire/train staff or consultants to manage accountability-related tasks, such as developing, implementing, and evaluating a quality improvement (QI) and utilization management (UM) plan.
- Conduct strategic planning efforts such as organizational and staffing assessments to ensure readiness to fully participate in the system transformation and new service design.
- Refine/define corresponding policies and procedures in response to new treatment documentation, authorization, and data collection requirements.

SUD providers are expected to make the necessary investments to enable the delivery of patient-centered and outcome-focused services.

Budgets and cost reconciliation reports need to reflect these appropriate investments.

PREPARING FOR LAUNCH

Understanding Your Business' Organizational and Clinical Strengths and Growth Opportunities

AND

SAPC Capacity Building Initiatives

Organizational Capacity Building Assessment and Benchmarking Tool:

Document helps non-profits explore areas of strength and opportunity in these areas:

Sample Worksheet

	Service Delivery and Impact				
Assessment Categories (6)	**LEVEL 1: Clear need for increased capacity**	**LEVEL 2: Basic level of capacity in place**	**LEVEL 3: Moderate level of capacity in place**	**LEVEL 4: High level of capacity in place**	**Select the level that reflects the organization**
1. Program/ Service Planning, Relevance & Integration	Programs and services vaguely defined and lack clear alignment with organization's mission, vision and goals. Programs and services seem scattered and largely unrelated to each other. Little intentional program planning. Programs and services typically developed in response to funding opportunities or based on untested ideas.	Some programs and services well defined and can be linked to organization's mission, vision and goals (strategic plan) and community needs and assets. Program offerings may be somewhat scattered or separated by "silos"-- not fully integrated into a clear strategy. Little or limited use of customer data. Some ability to modify existing approaches and programs and create new services based on customer	Most programs and services well defined and aligned with organization's mission, vision and goals (strategic plan). Most program offerings driven by community needs and assets and fit together well as part of clear strategy but some "silos" may remain. Some efforts to plan service expansion as appropriate.	All programs and services well defined and driven by mission, vision and goals (strategic plan), customer needs and community needs and assets. Program offerings are clearly linked to one another and to complementary services provided by others and overall impact on customer is clear. Organization expands services and builds new approaches and programming based	
2. Advocacy and Influencing Policy	Organization does not attempt to influence mission-focused policies on behalf of customers; never called in on substantive policy discussions.	Organization possesses some interest and skill in advocacy and public policy work; participates in some efforts to influence policy on priority mission-focused issues; some contact with elected officials and other policy makers. May be hesitant to engage in advocacy or influence policy due to limited resources or incomplete understanding of nonprofit advocacy/lobbying laws; engages in some training to develop advocacy capacity; some coordination with regional and national efforts.	Organization understands how to influence policy and is actively engaged in policy discussions at local, state or national levels (as appropriate) on mission-focused issues; has advocacy point person and board involvement in establishing advocacy development and engagement policies; has relationships with several elected officials and other policy makers focusing on mission-based issues; some successes in influencing policy decisions, often in collaboration with others. Understands and complies with applicable	Organization proactively and reactively influences policies on mission-focused issues in a highly effective manner, on local, state or national levels; always ready for and often called on to participate in substantive policy discussions and, at times, initiates discussions. Board adopts policy agenda consistent with the organization's mission. Has a grassroots network that engages in calls to action.	

- Mission/Vision/Strategy
- Board Governance
- Executive Staff Leadership
- Service Delivery & Impact
- Strategic Relationships
- Manage/Develop HR
- Resource/Revenue Development
- Finance and Legal Management
- Operations & Infrastructure

Available At:

http://publichealth.lacounty.gov/sapc/HeathCare/DMCODS/OrganizationalCapacityBuildingAssessmentTool.xlsx

BUSINESS CAPACITY BUILDING TRAINING AND TECHNICAL ASSISTANCE

California Institute for Behavioral Health Solutions (CIBHS)

CIBHS PROVIDER CAPACITY BUILDING INITIATIVE

Multi-Year Initiative to Support Providers in Building the Business Infrastructure and Capacity to Successfully Participate in the SUD System Transformation: START-ODS

TRAINING AND TECHNICAL ASSISTANCE

In-person and webinar trainings open to all SUD network providers and staff. Designed to provide an overview of key topics and concepts.

LEARNING COLLABORATIVE

Regional teams work together over a period of time to identify areas of need/growth and test strategies to create and sustain improvements in those areas at the agency and network level.

CIBHS TRAINING AND TECHNICAL ASSISTANCE CAPACITY BUILDING INITIATIVE

Anticipated Training Topic Areas January – June 2017:

- DMC Certification Workshops (Regional)
- Organizational Assessment and Readiness
- DMC Regulatory and Administrative Requirements (DMC-ODS Terms & Conditions/CCR Title 22/42 CFR, Part 2/42 CFR, Part 438)
- Growing Your Continuum of Care
- Preparing Your Organization to Implement an EHR-Like System
- Enrolling Medi-Cal Beneficiaries in Health Plans and Benefit Verification
- Role of QI/UM in Improving Patient Outcomes
- Staff Development and Restructuring

SAPC Panel – Provider Questions

• Clinical Services and Research	Gary Tsai
• Adult Services	Yanira Lima
• Youth Services	Timothy Duenas
• Policy, Planning, Communications	John Connolly
• Contract Services	Daniel Deniz
• Finance Services	Babatunde Yates

START-ODS

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control (SAPC)

WEBSITE: *www.publichealth.lacounty.gov/sapc*

START-ODS Webpage: *http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm*

START-ODS EMAIL LISTSERV: *SUDTransformation@ph.lacounty.gov*