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Preparing the Specialty SUD System in Los Angeles County for Payment Reform

February 22, 2023

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

Updates from the State – DHCS and County Next Steps

- **The California Department of Healthcare Services (DHCS) launches payment reform in July 2023. DHCS rates are between the State and County – NOT providers**
  - November 19, 2022 DHCS provided outpatient rates (includes intensive outpatient, Recovery Service, and Care Coordination)
  - January 23, 2023 DHCS provided inpatient withdrawal management (WM) rates
  - February 6, 2023 DHCS provided outpatient WM rates
  - February 14, 2023 DHCS provided opioid treatment program (OTP) rates
  - Pending DHCS residential and residential WM
- **SAPC is preparing for payment reform as follows:**
  - Analyzing DHCS provided rates to determine appropriate provider-level rates and Year 1 capacity building opportunity to prepare for Year 2 incentives
  - Collaborating with providers on service delivery costs by level of care
  - Meeting with providers monthly to discuss updates and obtain feedback
  - Collaborating with DMH around payment reform planning

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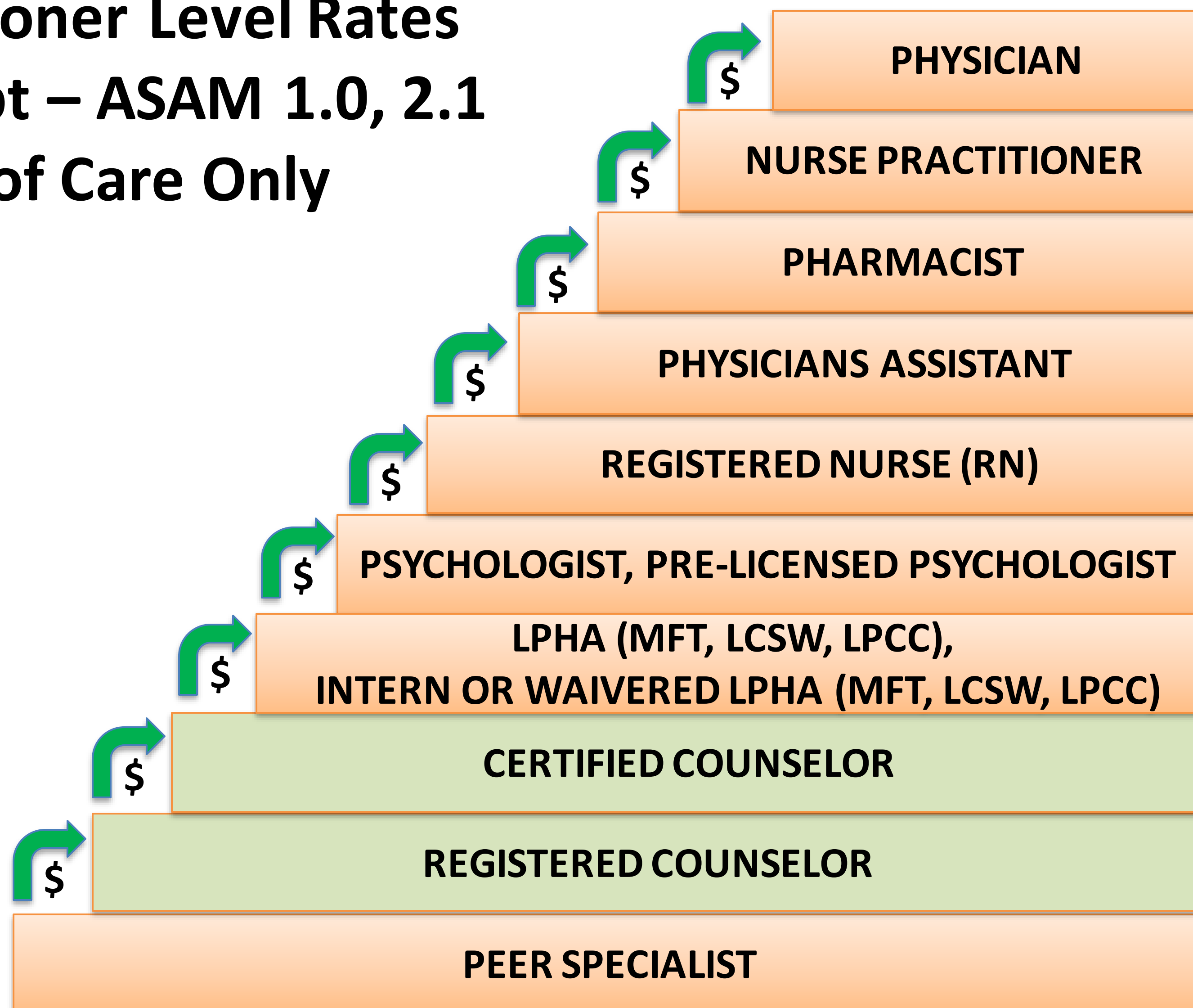
Practitioner Level Rates Concept

Michelle Gibson

Practitioner Level Rates Concept – ASAM 1.0, 2.1 Levels of Care Only



The rate paid for outpatient and intensive outpatient services (by CPT or HCPCS) will increase with the experience level of the practitioner documenting and delivering the direct service.

What are some advantages of practitioner specific rates?

- Incentivizes providers to diversify workforce that delivers direct services.
- Better supports increased costs for licensed/licensed-eligible positions.
- Creates opportunities to invest in strategies to address workforce shortages and turnover (e.g., salaries, benefits, recruitment incentives).
- Enables use of prescribers, including MD/DO/NP/PA's to deliver medications for addiction treatment (MAT) services.

What do outpatient practitioner specific rates mean?

Practitioner level rates are only available when the specified practitioner **DELIVERS** the **DIRECT** service.

Administrative functions (e.g., quality improvement, validating assessments, training) are included in the methodology of how the State arrived at the rates but are **NOT** directly reimbursed.

In summary – While DHCS' rates do include a certain number of administrative (indirect) hours, revenue generated by provider agencies will be optimized with more direct service hours and less administrative hours

How does California Rank? Investing in LA County's SUD Workforce!

- **81% of outpatient services are delivered by a substance use disorder (SUD) Counselor**
  - **50%** delivered by a **REGISTERED** substance use counselor
  - **31%** delivered by a **CERTIFIED** substance use counselor

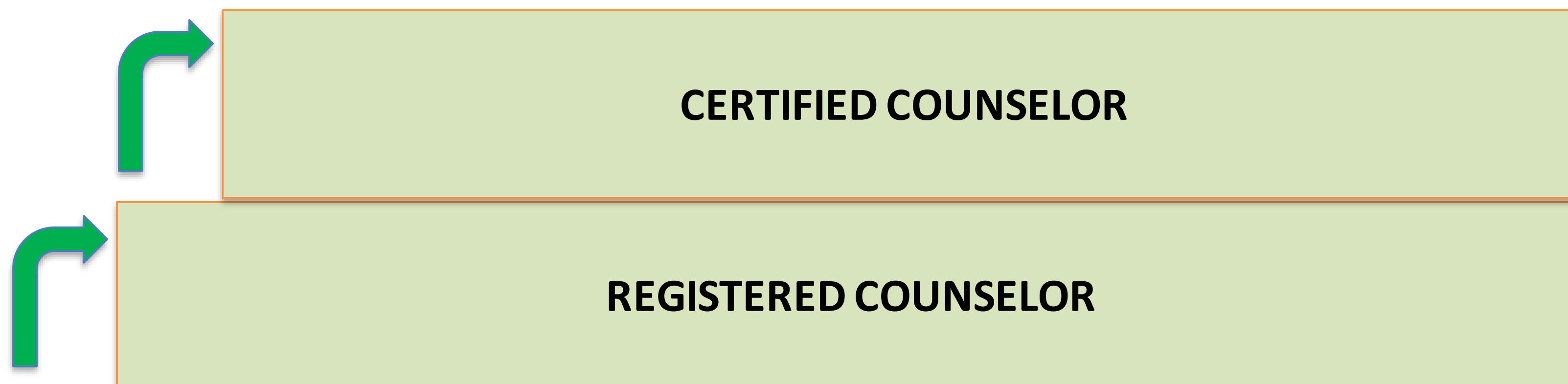
- **Where is California Now?**
  - California is 1 of 5 states that require less than 10 hours of SUD counselor training
  - 50% of States do not have a registered counselor option – all counselors must be certified

- **AB 2473 - By December 31, 2025, raises minimum educational standards for registered counselors from 9 to 80 hours, the same minimum standard for peer specialists now.**

How can LA County lead efforts to support the counselor workforce?
How can LA County get prepared for value-/outcome-based care?

Certified Counselor rates will be higher than Registered Counselor Rates. Why?

– Reflect educational and training differences
– Support higher salary and benefits cost for certified counselors
– Motivate providers to support registered counselors moving quickly to certification
– Create County investment opportunities to support registered counselor workforce
– Prepare for value-/outcome-based care now

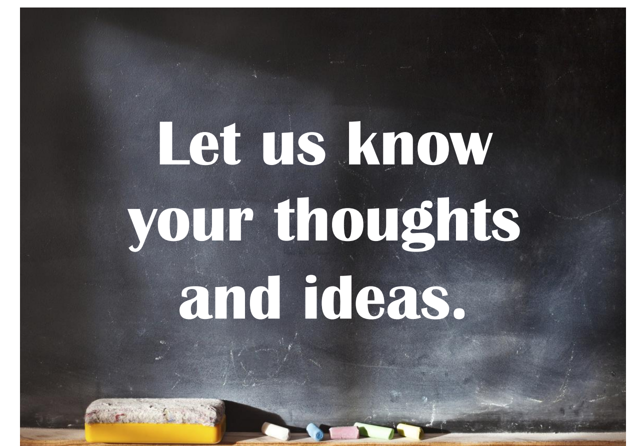


What are your ideas on how SAPC could fund incentives for providers to enhance recruitment and retention, and/or registered counselor to become certified and remain in the LA County SUD treatment network?

- ❑ Pay for Meeting Increased Certified Counselor Metrics
- ❑ Pay for Provider Time for Planning and Development
- ❑ Pay for Survey Completion to Understand Workforce Needs
- ❑ Tuition Reimbursement
- ❑ Compensated Training Time
- ❑ Coursework Reimbursement
- ❑ Other Ideas?

What could your agency do to reinvest revenue (gap between SUD treatment rates and costs) or streamline operations to realign expenditures (if no gap between treatment rates and costs) to support recruitment and retention of counselor workforce?

- ❑ Tuition Reimbursement
- ❑ Compensated Training Time
- ❑ Bonus for completing 80 hours training before AB 2473
- ❑ More competitive salary – livable wage
- ❑ Standard raises upon certification
- ❑ More attractive benefits
- ❑ Other Ideas?



LA County Overall Rate Setting Approach

- Increase investment in SUD services to move towards parity
- Enable provider investments to support real cost of quality care
- Create conditions to transition to value-/outcome-based care
- Enable SAPC incentives programs to support strategic investments
- Remain fiscally viable and accountable to public funds/funders
- Create conditions for LA County to lead the State in SUD care
- Partner with providers to achieve joint fiscal and service goals

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Procedure Codes for DMC Providers

Greg Schwarz

Overview

- Intro to HealthCare Common Procedure Coding System (HCPCS)
- Current Procedural Terminology (CPT®)
- CPTs® and HCPCS in the DMC Framework
- Billing Rules

Healthcare Common Procedure Code System

(HCPCs)

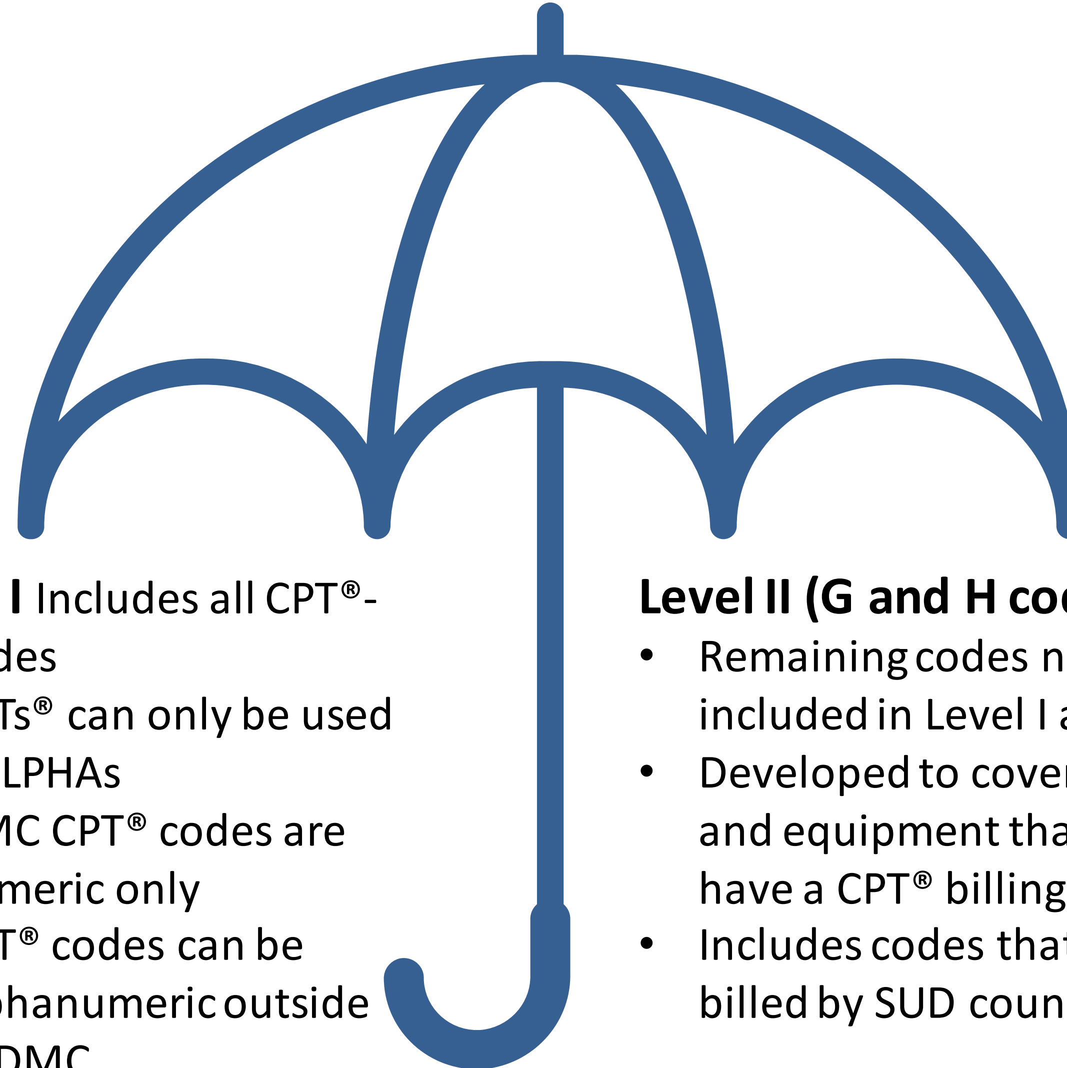
Healthcare Common Procedure Coding System (HCPCS).

- The overall procedure code system used for medical billing and governed by CMS

Comprised of Level I and Level II codes

- Level 1 codes are the Current Procedural Terminology (CPT®) codes that cover the majority of medical services as delivered by medical professionals and LPHAs.
  - CPT® are developed, managed and trademarked by the American Medical Association
- Level II codes were developed and managed by CMS to cover those services and equipment not covered under a CPT® code to assist with billing

Healthcare Common Procedure Code System (HCPCS)



Level I Includes all CPT®-4® codes

- CPTs® can only be used by LPHAs
- DMC CPT® codes are numeric only
- CPT® codes can be alphanumeric outside of DMC

Level II (G and H codes)

- Remaining codes not included in Level I as a CPT®
- Developed to cover services and equipment that did not have a CPT® billing code.
- Includes codes that can be billed by SUD counselors.

Why Differentiate HCPCS Level I and Level II?

Advantages and Challenges of Adding CPTs®

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Advantages

- Increases the services specific to LPHAs, including MDs, DOs, PAs, NPs
- Rates can be defined based on the discipline.
- CPTs® are ONLY available to be billed by **LPHAs**.
  - These will generally have higher rates as they are performed by LPHAs and medical professionals
- CPTs® are billable to federal Center for Medicare Services (CMS) to reduce the burden on Medi-Cal funding at the State.

Challenges

- Medicare rules must be followed when using CPT® codes, which are different than Medi-Cal.
- Separate modifiers must be used for CPT® codes and Level II HCPCS

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Billing Rules for CPT® Codes

Billing rules are restrictions placed on a particular code that must be adhered to in order to successfully bill. These are the general rules related to billing codes within DMC:

- Lockout Codes- Cannot be billed with other codes
- Dependent Codes- Must be billed with other codes
- Allowable disciplines- Can only be billed by specific disciplines
- Allowable places of service- Codes only allowed at certain places
- Allowable modifiers- various modifiers allowed for each code

Lockouts are codes that will be denied if billed on the same day as a predefined conflicting code

- Generally, they are not likely to be encountered in normal operations
  - Note: All outpatient services are locked out against inpatient and 24-hour services except for the date of admission.
- Example: Cannot bill 90791 and 90792 on the same day.
  - 90791- Psychodiagnostic evaluation that can be used by any LPHA
  - 90792- Psychodiagnostic evaluation with Medical service used by Licensed Physicians, Physician Assistants, and Nurse Practitioners
- Providers should not be scheduling multiple assessments on the same day by different providers.
- Example: Cannot bill an office visit on the same day as a home visit

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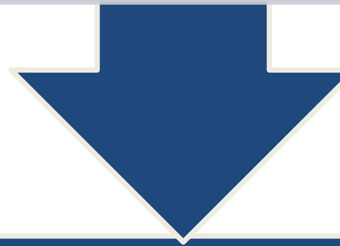
Dependencies are codes that can only be billed when another linked code is billed on the same day.

These are primarily used to indicate additional time spent on the service over the maximum unit for the primary service.



Also used to indicate a special circumstance occurred during the service

Interactive Complexity - an add-on code specific to psychiatric services and refers to communication difficulties during the procedure.	Sign language or interpretation services provided by a separate entity.

Interactive Complexity (90785) is an add-on code specific for psychiatric services and refers to communication difficulties during the psychiatric procedure.

The specific communication difficulties are present with patients who typically:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity may be reported with psychiatric procedures when at least one of the following communication difficulties is present:

- The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, or disagreement) among participants that complicates delivery of care.
- Caregiver emotions/behavior that interfere with implementation of the treatment plan.
- Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers.

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Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Interactive Complexity	90785	DMC – ODS: • LP • PA • Psy • Pharma • LCSW • MFT • RN • NP • LPCC • ~~AOD~~	DMC – ODS: All except 09 (Prison)	Cannot be billed with: 96170-96171,	90791-90792, 99202-99205, 99212-99215, 99217, 99234 – 99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350,	No	1 per allowed procedure per provider per beneficiary.	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 93, 95

Allowable Disciplines Under CalAIM

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Abbreviations	Discipline
LP	Licensed Physician
PA	Physician Assistant
Pharm	Registered Pharmacist
Psy	Psychologist (Licensed or Waivered)
LCSW	Licensed Clinical Social Worker
MFT	Licensed Marriage Family Therapist
LPCC	Licensed Professional Clinical Counselor
RN	Registered Nurse
NP	Nurse Practitioner
AOD	Certified/registered AOD Counselor
Peer	Certified Peer Support Specialist

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G2212- Your Billing Best Friend

- The following codes have a maximum of 1 unit (15 minutes) however the service will normally take longer than 15 minutes to deliver.
  - 90791, 90792, 90865, 90882, 90885, 90887, 90889, 96131, 99215,99217, 99236, 99310,99328, 99337,99340, 99345,99350, 99368,99409
- For every unit/15 minute after the initial unit, G2212 SHOULD be used to bill the additional minutes.
  - G2212 is not a standalone code
    - Cannot be billed by itself.
  - MUST be billed with one of the codes above.

Example: LPHA performed the ASAM assessment for 90 minutes.

Pre CalAIM

Billed by all disciplines using H0001 at 6 units for fixed rate

CalAIM

LPHA bills 1 unit of 90791

Then 5 units of G2212

Different rate for each discipline

HCPCS Level II Telehealth

- GT- Synchronous Audio and video
- SC- Audio Only

CPT® Telehealth

- 93- Audio Only
- 95- Synchronous audio and video

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Next Steps for Providers

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SAPC and Netsmart will configure Sage to include all the available codes per level of care and discipline type.

Additionally, billing rules will be configured and result in denials when not followed.

- Providers need to be cognizant of which codes can be billed by which provider type for a given service.
- The DMC Billing Manual (updated January 2023) is available for providers to review.
- SAPC will continue to provide trainings on the billing processes involved with CalAIM and Payment Reform.

Providers should continue to review all provider communications for any updates and attend relevant meetings.

There are no specific actions that Primary Sage Users can take at this time related to Sage as SAPC and Netsmart will be configuring Sage on your behalf.

Payment Reform offers a unique workforce development opportunities for the SAPC network related to the additional rate structures.

- Each discipline will have its own rate for the same outpatient service provided.
- Agencies should consider how to incorporate previously unused or underutilized disciplines into the treatment process.
  - E.g. medical directors/LPs now have several services that will be reimbursable using CPT® codes.
    - Specifically, Evaluation & Management codes.
  - LPHAs will have available assessment specific and family codes.

Secondary Sage Users

Secondary Sage Users should be working with their respective EHR vendors to ensure availability and compliance with the newly available HCPCS (Level I and Level II) codes.

Work with EHR vendors on configuring the billing rules related to available codes to avoid unnecessary denials.

Provide training to agency staff on the billing rules as configured within the providers primary EHR.

Fiscal Reporting

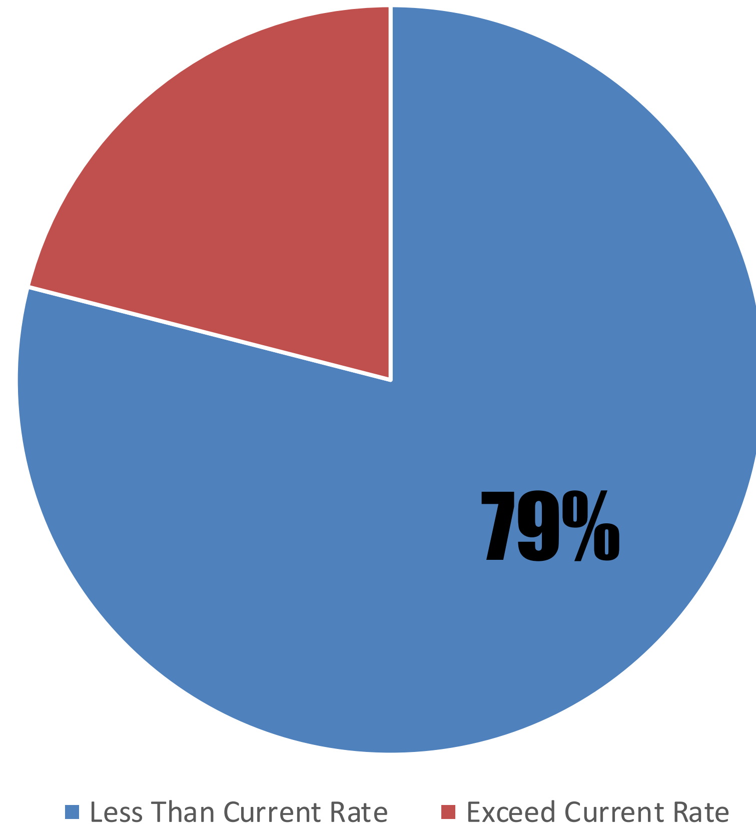
Daniel Deniz

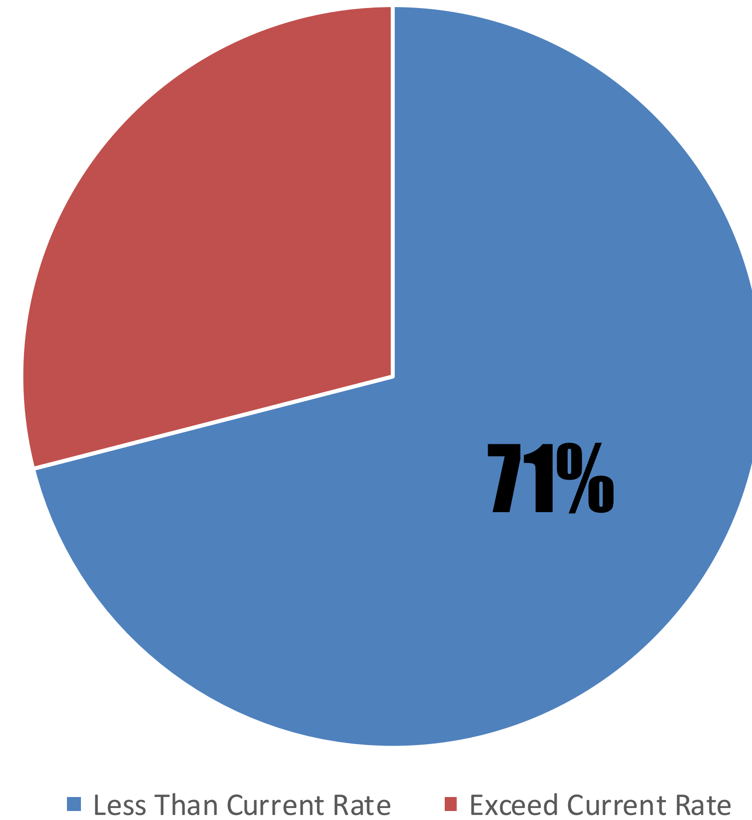
Fiscal Reporting Update

Report Recap

- 93% of agencies completed fiscal reporting
- Significantly streamlined tool (just 5% of DHCS tool!)
- Based on FY21-22 data
- Captured cost by Level of Care
- Better indicator of costs & aligned with organizational accounting
- **Top Two Costs: Salaries & Facilities**

Fiscal Reporting Update





Fiscal Reporting: *Lessons Learned*

Ensure costs are captured by Level of Care (LOC)

- Establish cost centers for each LOC
- # of hours staff work under each program
- No need to track by site
- Confirm cost allocation methodology with SAPC

Fiscal Reporting: *Lessons Learned*

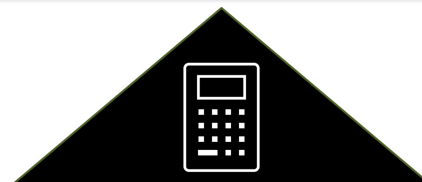
Include Program & Accounting Staff

- Establish information sharing between **PROGRAMS** and **ACCOUNTING** staff.
- Ensure accounting staff are aware of treatment guidelines and LOC differences.
- Ensure program staff are tracking time and expenses in a manner that supports accounting practices.

Fiscal Reporting: *Lessons Learned*

Monitor Revenue and Expenses

- Ensure all allowable services are being billed.
- Review files to confirm patient is enrolled in appropriate LOC.
- Identify and prevent potential deficit issues.
- REMINDER: CalAIM = Fee-for-Service (NO RECONCILIATION)



PROVIDER DISCUSSION

- How do you ensure information is being shared between Program Staff and Accounting Staff?

- How do you know you are appropriately reinvesting revenue?

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Provider Discussion

Amy McIlvaine

Thank You!

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!

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Payment Reform - Where is the Substance Use Disorder (SUD) System Headed?

Changes in 2023 and beyond

Level-Setting / Refresher Slides

REMINDER Behavioral Health (BH) Payment Reform

Value-Based Reimbursement
(various arrangement types)

Cost-Based Reimbursement

Lesser of Costs or Charges

Fee-For-Service

Bundled Payments

Shared Savings

Shared Risk

Accountable Care Organizations

Global Capitation

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 with incentive payments based on quality benchmarks, to some form of value-based reimbursement (likely capitation per DHCS)

PAST: Cost-Based

- July 2017 – June 2023
- Provisional FFS rate
- Volume-based (more services, more compensation)
- Contract reconciled at lesser of allowable costs or State approved claims
- Recoupments if costs are lower than rates paid
- Reinvest in program if rates higher only during current FY or excess recouped

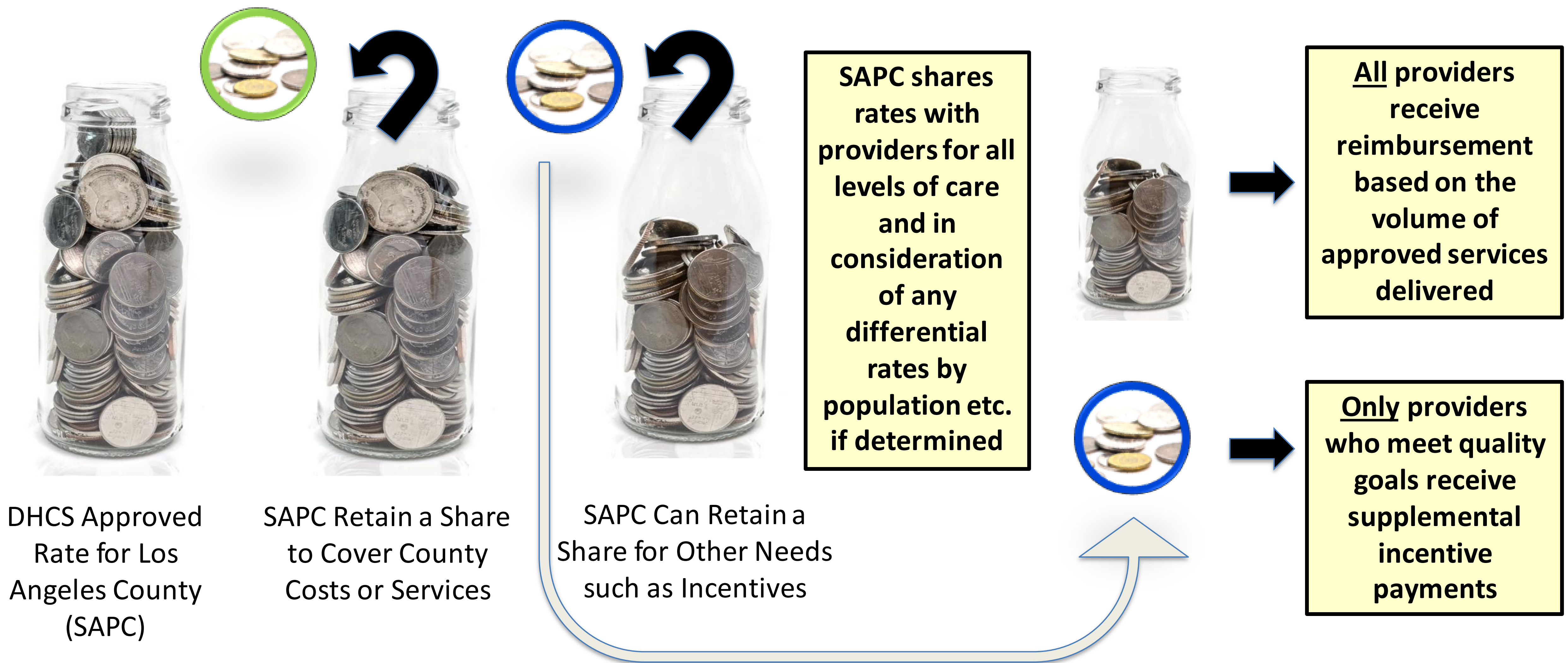
Payment Reform: FFS

- July 2023 – Approx. 2025
- Fixed FFS rate
- Volume-based (more services, more compensation)
- Contract not cost reconciled as based on State approved claims only
- No recoupments if costs are lower than rates paid
- Reinvest in program if rates higher than current costs during or after current FY

Future: Value-Based

- Approximately 2025+
- Capitation / Value-Based: Bundled rate for all services a patient needs, County and possibly providers
- Outcome-Based: Must provide enough quality-based services at right level of care to show patient improvement
- No additional payments or recoupments for losses or gains
- Invest in organization (staff, trainings, etc) to improve outcomes and avoid losses

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



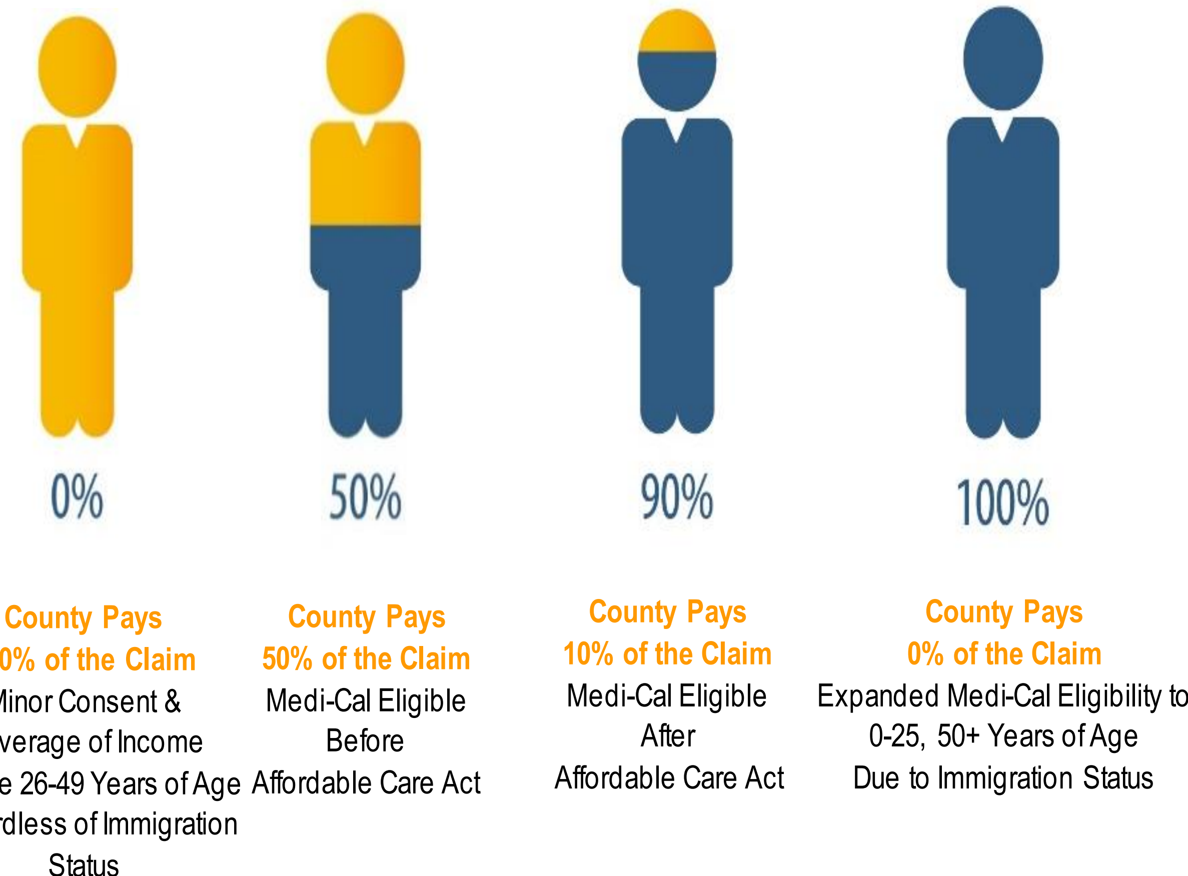
Why do the rates paid to providers matter to the County / SAPC?

For most services and levels of care, Counties are responsible for paying a share of each DMC reimbursed service with non-federal funds.

This means Counties need to set rates at a level that move the SUD system forward but are affordable given available matching funds.

Basic Medi-Cal Financing for SUD Treatment Services

State/Federal Share ➔



Drug Medi-Cal Funding Commitment:

- Federal/State Share
- Local (LAC) Share

FOR MORE INFORMATION ON PAST PRESENTATIONS

- **Payment Reform Meeting – December 13, 2022**
  - Presentation PDF: Link and Presentation Video: Link
- **Payment Reform Meeting – January 24, 2023**
  - Presentation PDF: Link and Presentation Video: Link

REMINDER

The payment reform provider meeting series is intended to provide a forum to discuss how rates and reimbursement is expected to change beginning July 2023. Because these discussions are happening before DHCS has provided full information on rates and DPH-SAPC has been able to fully evaluate feasibility of rates for FY 23-24 and strategies to support optimal SUD treatment services, content is considered conceptual and draft, and may change. Only when DPH-SAPC has full visibility on all DHCS rates and the impact of State decisions, can a final rates/reimbursement approach be determined.