Provider Advisory Committee Meeting

The Alhambra, 1000 S. Fremont Ave., Bldg. A9 East
Microsoft Teams
August 24, 2021

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

Welcome & Introductions

- Introductions
  - Chair
  - Co-Chair
  - New PAC Members
    - Jonathan Higgins, The Beacon House Association of San Pedro
    - Nora O' Connor, JWCH/Wesley Health Centers
    - Denise Shook, Behavioral Health Services
    - Edith Urner, Exodus Recovery

Updates for Provider Advisory Committee

- Meeting purpose and Expectations
- Alternatives to Incarceration (ATI) Initiative, Measure J and AB109
- SAPC funding opportunities
- BHIN notices

Los Angeles Department of Public Health
Substance Abuse Prevention and Control

August 24, 2021

Provider Advisory Committee Meeting

Highlights and Updates

August 24, 2021

Division of Substance Abuse Prevention and Control (SAPC)

WELCOME NEW PAC MEMBERS!

New Member	Agency
Jonathan Higgins	The Beacon House Association of San Pedro
Nora O'Connor	JWCH Institute, Inc.
Denise Shook	Behavioral Health Services
Edith Urner	Exodus Recovery, Inc.

SUD Provider Advocacy and the PAC

- **Alternatives to Incarceration and Measure J**: The SUD provider voice is needed to advocate for service opportunities for our population! Funding decisions are made here.
  - Calendar of Meetings: https://ceo.lacounty.gov/ati-calendar

- Approved Measure J Funded Projects
  - #3: SUD Treatment and Beds for Diversion Population (aka: "SUD Court Based Diversion") - $2M
  - #6: Harm Reduction Expansion – DPH-SAPC and DHS-ODR $6M total
  - #7: SUD Workforce Initiative - $1M
  - #23: Recovery Bridge Housing - $2M

SAPC Information Notice (IN) Updates

- IN 21-05: FY 21-22 Rates and Payment Policy Updates
- IN 21-01: COVID-19 Response - Discontinued and Replaced
- IN 21-06: COVID-19 Response – Discontinued all pandemic service accommodations except the following (see IN table for detail):
  - Expires 9/30/21: AOD certification 3-month extension
  - Expires 11/1/21: No modifier for telehealth/telephone claims
  - Expires 12/31/22: Assessments via telephone/telehealth
  - Expires 12/31/22: Group counseling via telephone/telehealth in RS/OP/DUI
  - Expires 12/31/22: Payment parity for telephone and telehealth services

Vaccine and Masking Mandates

- **Behavioral Health Information Notice No. 21-043:** Requirements for COVID-19 Vaccination Verification, Testing and Masking for Behavioral Health Facility Workers and as updated by **State Public Health Order** on August 5, 2021.

Vaccinations

All workers (paid and unpaid) who provide services or work in identified facilities (in our case SUD ASAM 1.0, 2.1, 3.1, 3.3, 3.5, 1-WM, 2-WM, 3.2-WM, 3.7-WM and 4-WM, and prevention staff working in or delivery services in such facilities) must be **FULLY VACCINATED WITH THE PFIZER, MODERNA, OR JOHNSON AND JOHNSON VACCINE FOR COVID-19 BY SEPTEMBER 30, 2021.**

Exemptions may be available with written declaration for (1) religious or (2) qualifying health condition reasons (with a written statement from an appropriate health care provider) with mandatory COVID-19 testing 2 times per week in acute heath care and long-term care settings or 1 time per week in other health care settings AND use of a surgical mask or higher-level respirator in the facility at ALL times.

The Contractor must maintain records to this effect.

Masking

Masks are required for ALL individuals regardless of vaccination status in the following indoor settings:

- Healthcare settings (including SUD sites)
- State and local correctional facilities and detention centers
- Homeless shelters
- Long-Term Care Settings
- Adult and Senior Care Facilities

Peer Support Specialist Program: 21-041 and 21-045

- **County Impact**: Determine when to opt-into inclusion of new services (H0025 Behavioral Health Prevention Education and H0038 Self-Help Peer Services) to be provided by certified peers specialist which are available as add-on DMC services. in OP/IOP/RSS and integrated into the rate for WM/RS.
  - ***Provider Impact****: Determine if/how you would like to incorporate certified peer specialist within your service model when this is launched by LAC and once the certification process has been finalized by CalMHSA which includes peer completion of the 80-hour training curriculum and passing the initial certification exam before service delivery AND 20 hours of continuing education every two years.*
    - SAPC is interested in your feedback about this new benefit and will provide more information on a forum to discuss this effort soon.
    - Additional information will be provided as it becomes available

Co-Chair Announcements
Kathy Watt

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Approval of Meeting Minutes
June 15, 2021 Meeting

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County of Los Angeles Health Agency & Department of Public Health

PAC 30-day Length of Stay Workgroup
Kathy Watt

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

PAC 30-Day Res LOS Workgroup Recommendations

Presented by: Kathy Watt

Who was involved?

PAC Workgroup Members

- **Kathy Watt**, Van Ness Recovery House
- **Cory Brosch**, Phoenix House California
- **Deena Duncan**, Volunteers of America Los Angeles/Southern California Alcohol and Drug Programs
- **Brandon Fernandez**, Cri-Help, Inc./I-ADARP, Inc.
- **Baldomero Gonzalez**, Fred Brown Recovery Services, Inc.
- **Christina Gonzales**, Principles, Inc. dba Impact Drug and Alcohol Treatment Center
- **Elan Javanfard**, Didi Hirsch Mental Health Services
- **Claudia Murillo**, House of Hope Foundation, Inc.
- **William Tarkanian**, Los Angeles Centers for Alcohol and Drug Abuse

SAPC Staff

- Kyle Kennedy
- Yanira Lima
- Julie Lo
- Jimmy Nguyen
- Megala Sivashanmugam
- Milan Spencer
- Belia Sardinha
- Kimia Ramezani

CIBHS Staff

- Amy McIlvaine
- Charlotte Bullen

Convening Dates

The workgroup meetings took place virtually for 90 minutes via Microsoft Teams.

- 1/28/21
- 2/18/21
- 3/4/21
- 3/18/21
- 5/20/21
- 5/27/21

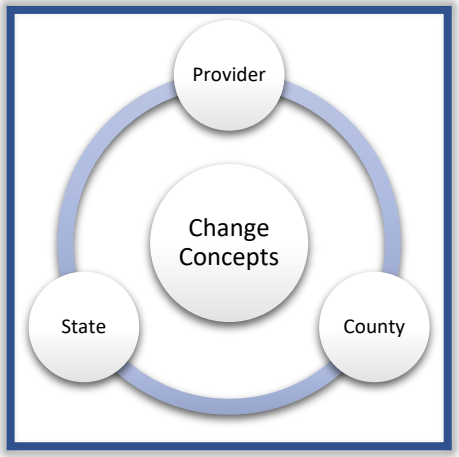
Additional meetings between CIBHS and Kathy Watt also took place to construct the final documents.

AIM

To identify how the SAPC Network of Treatment providers can meet the proposed DHCS Residential Length of Stay Average (included in the 1115 waiver extension approved January 1, 2021).

Identify ways to leverage all Levels of Care within the SAPC Network to meet this Length of Stay Average.

Brainstorming Process



- Key concerns and barriers were identified using Mural.
- Took a closer look at each concern and barrier and defined the pain points.
- Possible solutions were identified.
- Solutions were then classified as: Provider, County, and/or State who could facilitate/implement the change.

Key Concerns and Barriers

- Data
- Administrative Processes
- Billing and Reimbursement
- Housing
- Staffing, Training, Recruitment, etc.
- Continuum of Care
- Operational
- Patient Acuity
- Referral Sources

A "Closer Look"

Data
- Patient Data per Episode
- Cumulative Data (per year)

Administrative Processes
- EHR/Sage - UX design issues
- Cost (Admin Costs)
- Easier to discharge than to treat
- Enrollment and Transfers
- Documentation Overload

Billing and Reimbursement
- Authorizations and Denials Timer
- Lack of Housing
- Access to Sober Living

Housing
- Reimbursement and PHP
- Lack of Housing
- Access to Sober Living

Staffing, Training, Recruitment, etc.
- Knowing and Understanding the metrics of a value-based care.
- Shift of staffing levels (credentialing)
- Value of Residential Care
- Belief of efficacy of 30 day stay
- Train for triage for treatment
- Improve case management
- Workforce/higher credentials

Continuum of Care
- RBH
- Inappropriate level of care
- Culturally competent levels of care
- Understanding and Itlizing Withdrawal Management
- Lack of Level of Care

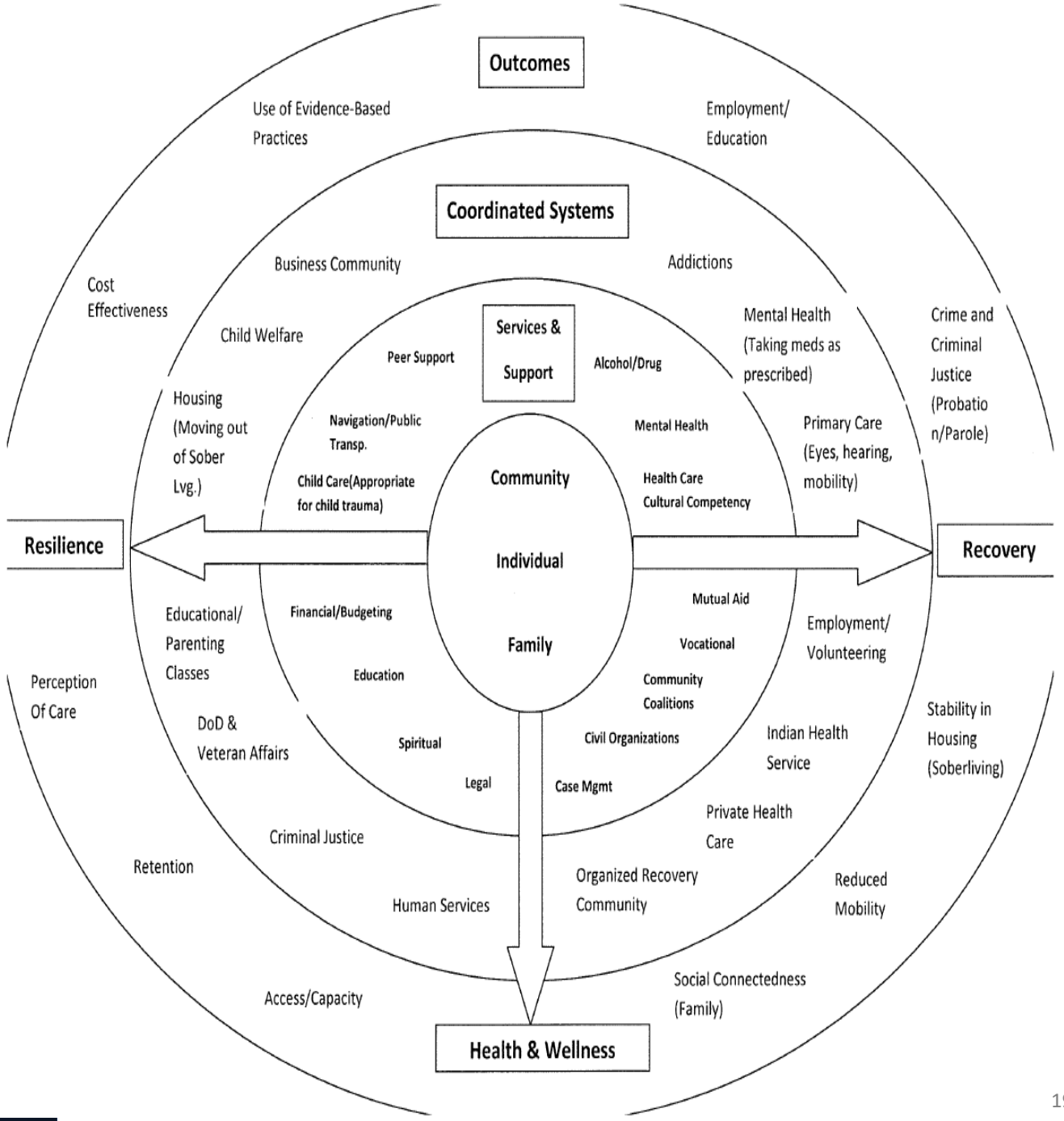
Operational
- Turnover cost
- Wear and tear on building, equipment, etc.
- Psycholocoal atmosphere of new pts. and the staff (the whole energy)
- Redesigning our workflow

Patient Acuity
- Identify patient acuity and level of care
- Co-occurring
- Psychosocial comorbidities
- Individualized and whole person care
- Addressing physical comorbidities

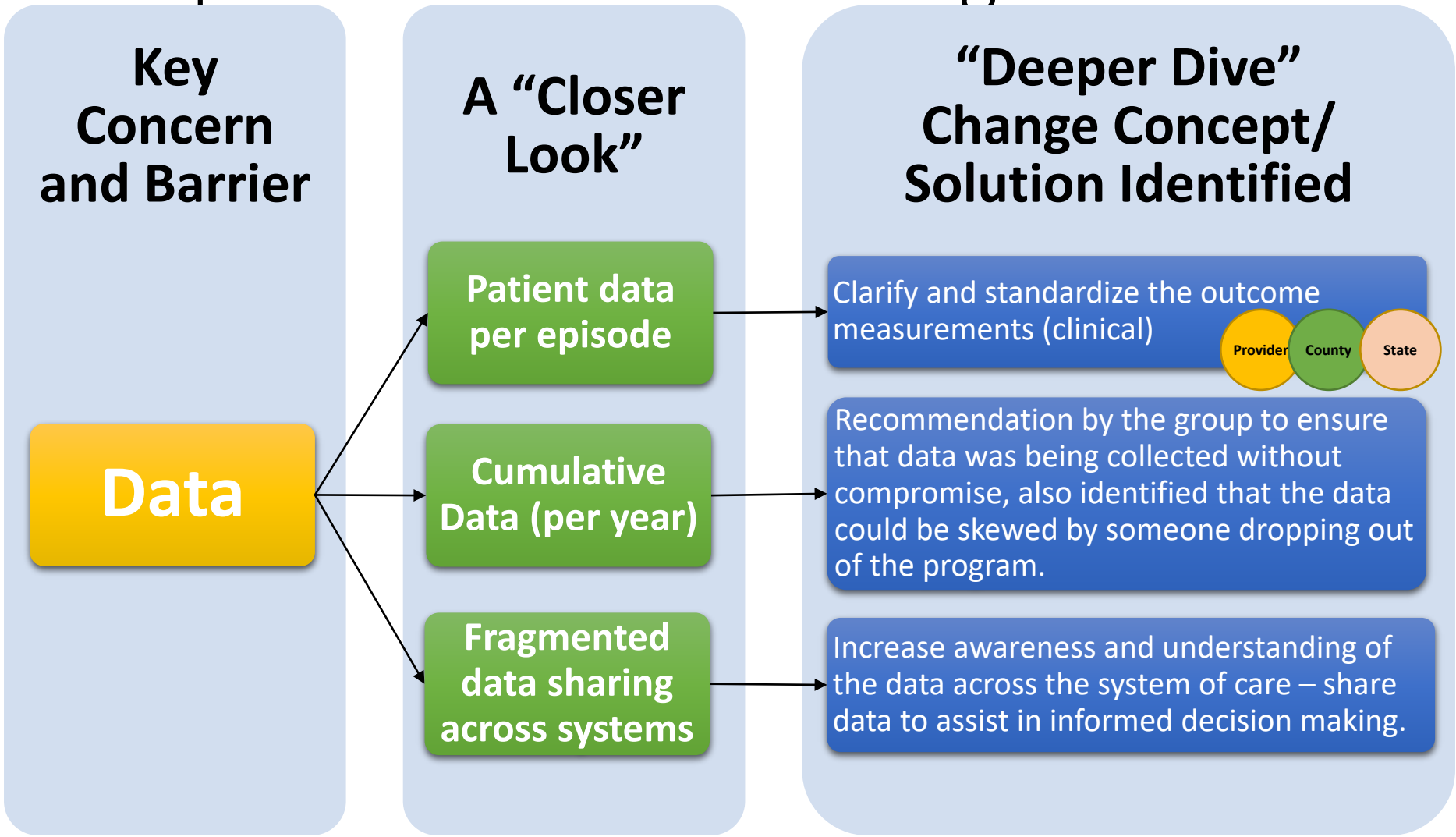
Referral Sources
- Mandated participants
- Educating referral source
- Warm handoffs and strategic partnerships

Patient Touch Points

Necessary Partners for Successful Patient Care



Example of the Brainstorming Process



Patient Acuity

- **Identify patient acuity and level of care**
- **Co-occurring**
- **Psychosocial, comorbidities**
- **Individualized and Whole Person Care**
- **Addressing physical comorbidities**
- **Primary care health disruption (ex. COVID-19, flu season)**

Please refer to page 10 of the report for more information.

Impact

- ✓The PAC workgroup was solution focused.
- ✓It was apparent that the concept of data sharing does not happen between providers and SAPC. Also, providers are not collecting data in real-time.
- ✓Realizing that in 30-days we may be able to stabilize, but we are not going to have time to treat.
- ✓The SUD field is worried about recidivism and holding on to the patient without losing them back into their addiction.
- ✓Realizing that this is going to rely on system transformation.
- ✓The current system is siloed (treatment and payment process).

Next Steps

- The PAC Workgroup meetings and discussions were driven by thinking of **patient outcomes** and not what is easiest for the provider.

- To look forward to positive patient outcomes, we look forward to continued open dialogue with PAC, Dr. Tsai, and SAPC leadership to work together to operationalize county and provider solutions.

Introduction to Value-Based Care

Michelle Gibson, Deputy Director

Substance Abuse Prevention and Control
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LAC SUD Payment Reform: Past, Present and Future

How we were reimbursed before DMC-ODS?

- Before DMC-ODS launched in July 2017, most contracts were ultimately based on "**Cost Reimbursement**". Therefore, final payment was only based on the allowable cost to deliver treatment services.

If fee-for-service claims for patients served are below allowable expenditures, SAPC pays the difference.

- It was not based on volume of patients admitted/services delivered; and
- It was not based on whether patient outcomes improved.

How are we reimbursed since DMC-ODS?

- After DMC-ODS launched in July 2017, all treatment contracts will ultimately be reimbursed based on "**Cost Reconciliation**" or the lesser of approved costs or approved charges (rates).
  - Volume of patients admitted, and corresponding approved services delivered, are the primary factor in determining final payment; but
  - Not whether patient outcomes improve.

If fee-for-service claims for patients served is above allowable expenditures, provider pays back SAPC the difference.

If fee-for-service claims for patients served is below allowable expenditures, SAPC does not pay the difference.

How will Counties be reimbursed under CalAIM?

- CalAIM includes payment reform and will change the way that behavioral health services are financed from the county to the state, shifting from a cost-based certified public expenditure (CPE) methodology to an intergovernmental transfer (IGT) arrangement.

- The California Department of Health Care Services (DHCS) will change the reimbursement model with Counties effective July 2023, with intensive planning efforts starting now to establish rates and payment systems, including updates to EHRs and CPT billing codes.

- This change necessitates significant organizational change for both SAPC and provider operations.

How will providers be reimbursed under CalAIM?

- The broader trend in Medi-Cal financing is towards incentivizing patient care that improves patient outcomes, also known as value-based care.

- To prepare for this eventual change, providers will need to learn the differences between **cost-based reconciliation**, **fee-for-service**, and **value-based reimbursement**.

- *This presentation is intended to provide a conceptual understanding of these financing models, as SAPC awaits more details from DHCS regarding the implementation of payment reform.*

Transitioning through Payment Reform Models

The Evolution of SUD Financing

- **Now: Cost Reconciliation**
  - Rates paid via a provisional fee-for-service (FFS) rate (per the Rates and Standards Matrices) to the facilitate monthly claiming process.
  - At the provider-level, the contract is ultimately settled at lesser of costs or charges (rates) during cost reporting (*which is several years delayed meaning many providers whose costs were lower than the rates paid have not experienced repayment plans yet*).
  - At the SAPC-level, the non-federal share is paid via certified public expenditures (CPE), with payments often being significantly delayed.

- **Next: Fee-For-Service (FFS)**
  - FFS Rates are paid via a fixed rate schedule based on CPT codes.
  - At the provider-level, the contract is paid based on the rates, however, mechanisms will be implemented to ensure appropriate spending and investment in quality care.
  - At the SAPC-level, the non-federal share is paid via intergovernmental transfers (IGT).

The Evolution of SUD Financing (cont'd)

- **Future: Value-Based Care**
  - Rewards health care providers with risk-based incentive payments focused on improvements in the overall quality of care, service efficiency, cost management, and patient and population health improvement.
  - Strives to meet the triple aim of better care for individuals, better health for the population, and lower costs.
  - Fosters care coordination of a health care team through increased communication and data sharing to monitor and support the wellbeing of an individual.
  - Enables provider flexibility in making informed care decisions.

Fee-for-Service (FFS) vs. Value-Based Care (VBC)

FFS

- Also known as volume-based care, FFS incentives are based on increased volume and quantity of services rendered.
- Financial incentive is focused on quantity as opposed to quality.
- Unbundled services.
- May enable a fragmented health care system.

VBC

- Focuses on delivery of holistic, patient-centered care.
- Improves accountability through incentivizing improvements in care quality and health outcomes.
- Allows for flexibility to facilitate innovation in the ways providers care for patients.
- Allows for flexibility to continue to expand the diversity of workforce disciplines to support the provision of comprehensive services.

Cost-Based →	Volume-Based →	Value-Based
Paid according to allowable cost amounts.	Paid according to number of allowable services delivered (i.e., fee-for-service).	Paid according to the overall care for individuals and specified quality metrics.
Focus is on *cost of delivering services*.	Focus is on the *number of services delivered*.	Focus is on *efficiently delivering services to achieve incentivized outcomes*.
Example: Cost for one LPHA and five SUD counselors to deliver 1000 units of services is $100,000		
Straight Cost: ABC Recovery is paid $100,000 to support these allowable costs. Cost Reconciliation: ABC Recovery is paid $100,000 if approved claims are submitted at that amount and it is substantiated by $100,000 in allowable costs.	ABC Recovery is paid for the 1000 units of services delivered, regardless of the costs of delivering those services. For example, if the rate for the service was $100 per unit of service, then the amount paid would be 1000 units x $100 = $100,000.	ABC Recovery is paid neither based on cost or the number of units of services delivered, but instead paid to provide all needed SUD services for a beneficiary for a one-year period, with incentive payments if certain quality benchmarks are met.

Role of the SUD Provider in VBC

- Ensure quality controls to appropriately balance quality service delivery and financial management.
- Increase coordination and communication with health care team (includes other health care professionals) to support patient care.
- Be innovative and flexible in their provision of services and make more informed choices towards a patient's health.
- Case management is critical to help ensure patient needs are met.
- Use evidence-based practices, IT infrastructure and platforms, and data analytics to track and report on individual and population health, patient engagement, and health event outcomes.

Role of the Managed Care Entity (SAPC) in VBC

- Adopt a specific payment method and set VBC goals and metrics focusing on quality and improvement outcomes.
- Administer a comprehensive benefit package to create a value-based care program arrangement for wide-scale adoption.
- Share upside and downside risk with providers to facilitate appropriate planning.
- Invest in health care IT infrastructure and platforms and utilize data to receive payment and awards.
- Support implementation of more advanced value-based payment approaches over the life of its managed care contracts.

Common Types of VBC Models

- **Shared-Risk** - Providers share financial risk in providing patient care.
  - For example, providers participate in rewards from net savings and participate in losses if there are excessive net costs.

- **Population-Based Payments** - Providers are paid a fixed payment amount per patient for a period of time; wide array of services are covered for a specified period of time.
  - For example, all patient health care needs are covered over the course of year and is independent of the number of services needed.

- **Pay-for-Performance (P4P)** – Provider payments are linked to metric-driven outcomes and practice improvement.
  - Evaluates process, quality, and efficiency.
  - Providers meet defined quality metrics that can focus on clinical outcomes, cost management, patient experiences, or data utilization.

Insights on VBC

- Can facilitate financial sustainability for providers, plans, and governmental entities.
- Rewards health care providers with risk-based incentive payments focused on improvements in the overall quality of care, service efficiency, cost management, and patient and population health improvement.
- Coordinated care and a streamlined delivery system will increase access to care and better health outcomes.
- Providers have flexibility in the provision of care and can have higher patient satisfaction from improved care efficiencies.

Next Steps

- SAPC plans on engaging its treatment network around payment reform once more details from DHCS are clear.

- For now, SAPC wants to ensure its treatment network is familiar with the shift from the current cost-based payments models to value-based models so it can begin to plan accordingly.

CLAS/CCCH Updates

Antonne Moore, Chief, Equitable Access & Promotion Unit

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

Committee on Cultural Competence & Humility Updates & Next Steps

Antonne Moore, Strategic Network and Development Branch (SND)

C3H General Updates

- C3H is currently in the action planning process
- C3H, in collaboration with CIBHS, has identified **Key Priority Areas** (KPA) and objectives to implement over the next 2 years
- Will include a general assessment of need, targeted action steps, and outcome data associated with cultural and linguistically appropriate services (CLAS)
- KPAs include methods to diversify workforce, enhance language assistance, and streamline data collection

KPA #1: Culturally Reflective Governance, Leadership, & Workforce

Objectives

- Increase efforts to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to service populations.
- Provide education and training of governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Develop and nourish a climate that supports and promotes a diverse workforce.

KPA #2: Communication & Language Assistance

Objectives

- Improve timely access to services for people who have limited English proficiency.
- Ensure availability of services in threshold languages including competent bilingual staff and services, and accessible language assistance services.
- Provide easy-to-understand print, multimedia, and signage for critical patient informing materials in threshold and other languages and make available digitally on the SAPC website.

KPA #3: Culturally Reflective Planning & Operations

Objective

- **Ensure development of culturally and linguistically appropriate goals, policies, and management accountability that are infused throughout the organization's planning and operations.**

KPA #4: Data Collection, Regular Assessments & Accountability

Objectives

- **Collect and maintain accurate patient population health outcome data.**
- **Ensure regular assessments of community assets and needs are conducted and used to plan and implement services that respond to the cultural and linguistic diversity of service population.**
- **Conduct ongoing assessments of SAPC's CLAS-related activities and integrate into measurement and continuous quality improvement activities.**

Next Steps

- Complete action planning process – September 2021
- Return to PAC to discuss relevant action items
- Additional series of trainings with Dr. Marks for both supervisors and staff
- Share finalized plan

PAC Member Items

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PAC Member Items

- Open Discussion

Public Forum

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Public Forum

- Public comments or feedback

Adjourn
Next PAC meeting:
October 21, 2021 2 PM

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