



Health Care Reform In California's SUD Treatment System

Overview

There is a constellation of factors stemming from Federal policy changes that will have an impact on the SUD treatment field nationally and in California.

- National Drug Control Strategy
- Parity
- Health Care Reform
- 1115 Waiver

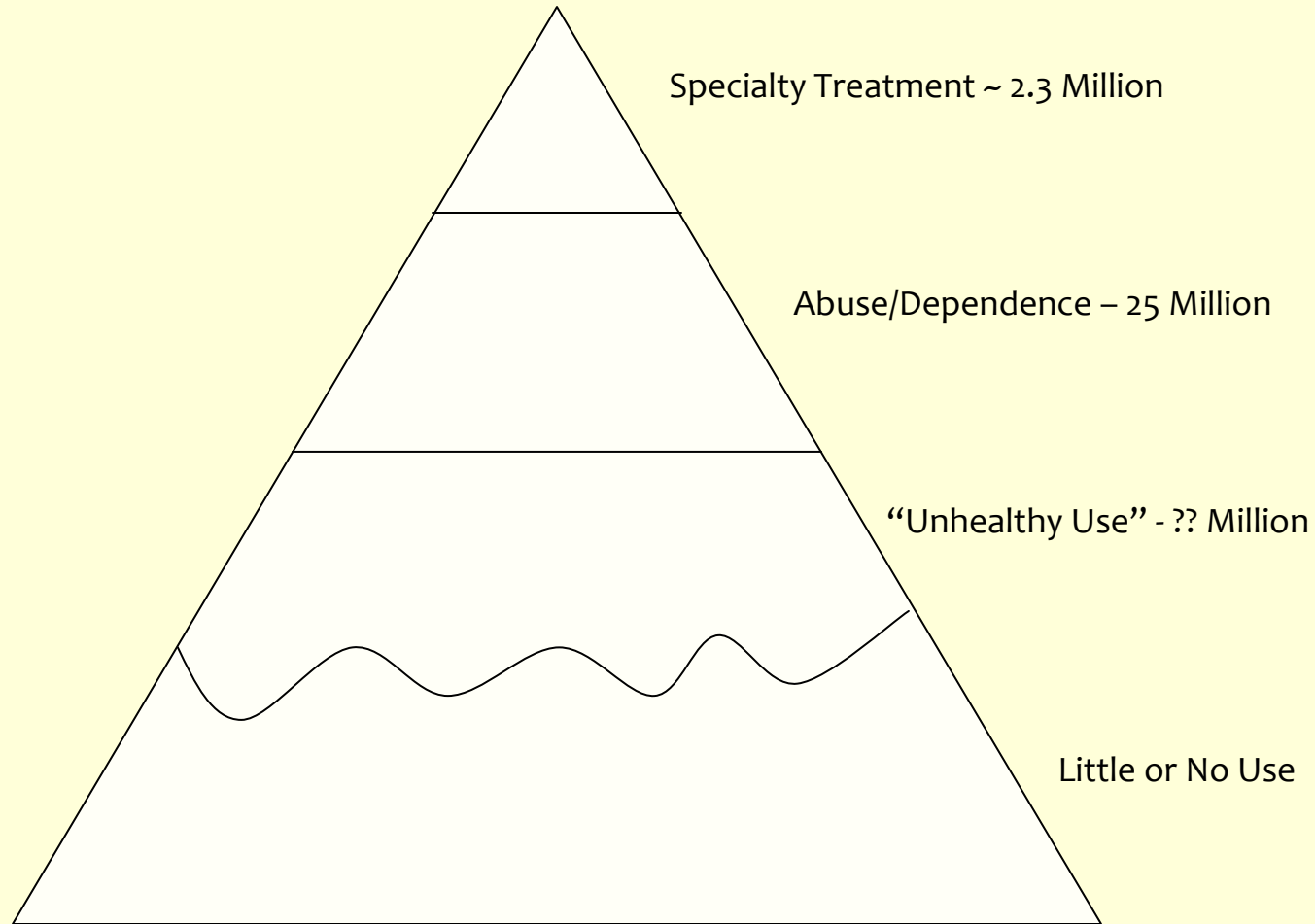
National Drug Control Strategy for FFY 2011

- \$26 Million to enhance SU care in Federal Health Systems.
 - First step in federal strategy for integration.
 - Provides for expanding SUD workforce and for training.
- \$4.2 M for training and administrative activities to expand use of SBIRT.
- \$9.9 for Access to Recovery treatment voucher program

National Drug Control Strategy for FFY 2011

- \$15 Million for Drug Courts & Offender Reentry Courts
- \$15 Million for “Prevention Prepared Communities”
- \$32.6 Million for data systems to measure local drug use impacts and emerging trends.
 - Performance measurement
 - State grants
- Block Grant remains at prior year level.

Population Segments in the National Drug Control Strategy



Parity

- Applies to MC managed care plans.
 - Does not pertain to DMC in its present form.
 - DMC must be restructured in order to participate in Parity
- With regard to parity in the private sector
 - Limited ability of most public sector SUD providers to participate and compete.
 - Workforce issues are significant.

Health Care Reform

- SUD services a “Essential Health Benefit”
- Coverage Expansion
 - 133% FPL = an additional ~ 1,000,000 persons aged 18 – 64 in California
- State Option to Provide Health Care Homes for Persons with Chronic Conditions (§2703)
- SUD staff considered a component of the Health Care Workforce

Health Care Reform

- Locus of SUD services moves from community based programs to health system. Payment shifts from Block Grant to insurance – both private and Medicaid.
- SUD treatment in CA does not have a medical necessity threshold beyond DSM IV abuse and dependence.
 - Hence the distinction between specialty and ‘regular’ care has not been clearly delineated in terms of treatment methods or clinical presentation of the client.

Confidentiality

- Under 42 CFR, Part 2 confidentiality has been program-defined. Increasingly, SUD services will be in the EMR and accessible to all in the health system.

Confidentiality

- As counties move to implement EHR's attention needs to be paid to the way in which different classes of system users have access to confidential information in the EHR.
- This needs to be a vendor requirement.
- In the absence of state or federal standards, counties can develop their own.

1115 Waiver

- The waiver will serve as a bridge to health care reform and will serve as a means to test integrated approaches to SUD care.
- County involvement is essential so that the pilots help create models of SUD care for statewide adoption in 2014.

1115 Waiver

- Broad discretion in the design of BHI pilots.
 - Counties provide match to FFP
 - No risk to state
- At present, the interest seems to focus on the Coverage Initiative counties.
- RFP's issued in Jan 2011.
- Pilots start in Jan 2012.

1115 Waiver

- Importance of waiver
 - Establish a model for DMC 2.0
 - That is, an organized system of care utilizing some of the HCR administrative, operational and fiscal concepts.
 - Test reimbursement, provider network and administrative approaches.
- If DMC goes away, then integration with coverage initiatives will help develop service and reimbursement models.
 - Help identify options in a carve-in environment.

Chaos Theory

- Over the next 5 years, in a very fluid environment, how do all these factors come together to make improvements in the field and to further the integration of SUD services into primary care.
- What steps does the field take to find its way?

A Fluid Environment

- SUD services will become a part of primary healthcare.
- Not all SUD services will be provided in a primary care setting. Not all SUD caseloads will be served (entirely) in a primary care setting. These will define the SUD specialty.
- There are separate tracks in HCR for private and public sectors – private insurance vs. Medicaid.

A Fluid Environment

The growth in financing is likely to focus on the private sector and in the healthcare rather than the SUD arena.

- The first step will be an increase in SBIRT related funding for FQHC's.
- As Medicaid eligibility expands in 2014 to single adults with higher income levels, there will be increased opportunities for AOD treatment providers.
- Private sector expansion may or may involve existing SUD treatment providers. Not all meet insurer standards in terms of accreditation or licensed staff.

Changing Roles and Relationships

- HCR will change relationships between county AOD Administrators and providers.
- 'Difficult' providers may well be the ones most likely to succeed in an HCR environment.
 - i.e., those with data systems (incompatible with county system), diverse revenue base. not dependent on block grant.
- Mom & Pop recovery centers, niche providers will need support or will disappear.
 - One of the reasons for contracting with CBO's is to be able to tap into the communities they serve. Communities that might otherwise experience disparities in access or outcomes in the broader system.
- Role of state vis-à-vis counties will change..
 - Audits, client protections, move what remains of SAPTBG.
 - What if Block Grant moves to HRSA and funds are provided directly to programs like in the FQHC system?

Laying the Groundwork

- Stay informed on HCR developments
- Learn about the local health care system(s)
 - How many covered lives
 - Physician panel sizes
 - Visits per year in general and specialty care
 - PMPM costs
 - What are BH benefits?
 - Who are BH providers
 - What are the requirements for provider participation?

Laying the Groundwork

- Engage and develop relationships with the local health care system
 - County health system
 - FQHC's
 - Medi-Cal managed care plans
 - Community clinics

Laying the Groundwork

- A first step is to assess your county's readiness for HCR and primary health/behavioral health care integration.
 - An examination of the degree of MH and SUD integration within a behavioral health system will need to occur.
 - Use self assessment guide to determine a good place to start.

Laying the Groundwork

Study capacity building needs in your provider network.

- Organizational (e.g., develop an alcohol and drug program strategic plan for HCR; develop Medi-Cal claiming capacity)
- Adoption of Evidence Based Practices
- Information Technology
- Workforce

Readiness Assessment - Linkages

- Is the County FQHC certified?
 - Do working partnerships exist with FQHC's (county or non-county)?
- What about other health systems or providers?
- Are there any current primary care integration projects?
 - SBIRT
 - Frequent Utilizers
 - HIV
 - Perinatal
 - Others?
- County AOD Program understands values, needs, constraints and incentives of primary care system.
- Is there clinical integration with Mental Health services?
- Any communication/partnership with Medi-Cal health plan(s)?

Readiness Assessment - IT

- Does the county have and use data systems other than CalOMS for system management?
- Does the county have the capacity to analyze and report data for decision support and performance management? What capacity exists for analytic or geographic analysis?
- Are there processes in place to ensure data quality?
- Can AOD, MH and Health systems databases communicate?
 - At what level?
 - Are linkages between MH, primary care, and AOD databases done on a one-time custom basis or routinely?
 - Is there a common medical record number or other means to link records?
 - Any data communication/partnership with Medi-Cal health plan(s)?
- Does AOD data system include an EHR? Are providers using it?

Readiness Assessment - Service Delivery & System Management

- Do program providers operate under County direction.
- Is there a process in place for care management & coordination across modalities?
- Does County control access to SUD treatment through a standard placement or authorization process?
- Do SUD programs operate as a system or as independent providers?
- Is there a systemwide quality management process?
- How closely do county operations mirror typical health plan functions?

Readiness Assessment - Providers

- Providers are informed about HCR and models for primary care/behavioral health care integration
- Providers are generally ready, willing and able to move in a new direction. If asked to deploy current staff in health clinics, would they do this or resist? Are providers willing to serve non-traditional SUD populations (e.g., heavy users without an abuse/dependence diagnosis)?
- How many are DMC certified
- How many licensed staff.
- Do providers have a medical director, medical consultant, or psychiatric support?
- Are any accredited – CARF, JCAHO
- Anyone doing insurance billing?
- Adoption of EBP's
- Any NIATx or COSSR participants
- Do any have internal data systems for capturing practice based evidence?

Readiness Assessment - Other

- Is there enough interest and awareness to begin a local planning process to educate stakeholders and prepare.
- Are there political considerations that would constrain county reallocation of resources and redeployment of provider services?

Health Plan Functions

- **Governance**
 - Provide governance for the SUD Plan that meets federal/state contract requirements and administer the contract.
- **Provider Relations**
 - Ensure adequate service capacity for each region, manage relations with network providers, coordinate with other systems, and meet other contract requirements.
- **Billing & Reimbursement**
 - Design payment mechanisms and manage provider payment and third party coordination processes.
- **Member Services**
 - Ensure enrollees are properly informed, provide customer service, ombudsman service, and manage grievance system.
- **Care Management**
 - Design and manage a care management system addressing access, authorization, intake and assessment, coordination of care, and ongoing utilization and resource management.

Health Plan Functions

- **Quality Management**
 - Design and manage a quality management system, working under an annual quality plan to monitor performance and outcomes and to improve services.
- **Information Technology**
 - Design and manage IT system to collect, analyze and submit data to appropriate bodies and to analyze system cost and performance.
- **Decision Support**
 - Develop and manage data warehouse; design and publish useful reports to support decision making at every level of the Plan. Analytic and GIS capacity
- **Accounting & Fiscal Management**
 - Provide financial planning and management for the Plan and meet contract reporting requirements.
- **Compliance**
 - Design and operate compliance plan.
 - HIPAA, ADA, Audits

Next Steps

- Relationship Building
 - Contact primary care organizations; develop a list of questions for the initial meeting and a “pitch” for ADP involvement in helping them to contain costs and achieve better outcomes; interview key allies (e.g., health department director) to learn primary care’s values, needs, constraints and incentives related to intervention/prevention with SUD’s.
 - Provide training opportunities.
- Engage FQHC’s
 - Do they provide SUD services? Mental health services?
 - Can County provide SUD referral resources to FQHC’s?
 - Can County provide outstationed staff for SBIRT?
 - Find out how FQHC’s unit of services rate from the Feds is built (e.g., what services are included in the rate setting process) and which staff bill directly vs. being subsumed under the overall rate; how often is the FQHC rate rebased?

Next Steps

- Get providers DMC certified
 - Only half of California's ODF providers are certified. Only 33% actually bill DMC.
 - Consult with ADPI on DMC application process
- Investigate integration opportunities with county health system.
 - Outstation SUD consultants in PC settings
 - Outstation PC providers in SUD programs
- Exert greater control over provider network.
 - Prioritize referrals from health system.
 - Establish a single point of entry and care coordination for primary care referrals (and others).

Next Steps

- Identify providers of services to clients for non-SMI patients.
 - Behavioral health concerns in primary care are not restricted to the SMI populations.
- Engage Medi-Cal Managed Care Plan
 - What data/studies would you want to provide them with by way of introducing the subject to them?
 - Analyze number and costs of common clients.
 - Would they entertain a proposal for SUD services?
 - What sort of data would they want to document the business case for reimbursing SUD services within current capitation?

Next Steps

- Database match with MH, SUD and health system clients.
 - If able to identify common clients, study health care costs and utilization patterns pre- and post- treatment.
- Capacity Building – System
 - Develop an County AOD strategic plan for HCR.
 - Collaborate with MH to develop a joint strategy for behavioral health/primary care integration
 - Hire medical director/consultant.
 - As County AOD system migrates to EHR, ensure that EHR has capacity to manage key HCR functions (e.g., track third party billings and treatment authorizations, link to MH and primary care EHR's, track costs and outcomes for selected groups of clients, capacity to link contract provider EHR with County health system EHR)

Next Steps

- Capacity Building – Programs
 - Build or buy? – Invest in current providers or find new ones?
 - Investigate insurance plan provider requirements.
 - CARF/JCAHO accreditation.
 - Incorporate fiscal, clinical and other performance measures into provider contracts.
 - Facilitate mergers of local non-profits in order to maintain niche services and to build/maintain infrastructure needed to handle sophisticated HCR business requirements.

Next Steps

- Capacity Building – Workforce
 - Build or buy?
 - Establish/revise County and provider staff minimum qualifications and pay scales to support more licensed/degreed staff. Use contracting process to help build capacity in provider network.
 - Conduct training for staff in primary care integration EBP's (e.g., SBIRT) and primary care system navigation.

Next Steps – Macro Level

- Restructure DMC as an organized system of care.
- Smaller counties might consider regionalization.
- ADP expedite provider DMC certification process.
- CADPAAC involvement in state level discussions – Exchanges, benchmark benefits.

Next Steps

The one thing NOT to do -

ADPI

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