County of Los Angeles
Public Health

OPENING: All Treatment Provider Meeting

- **SAPC's 10-Year Payment Reform Roadmap**
- **Behavioral Health Administrative Integration**
- **Prop 1**

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COUNTY OF LOS ANGELES
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SAPC's 10-Year Payment Reform Roadmap

SAPC 10-Year Payment Reform Roadmap

Key Terms:

- **Value-Based Reimbursement or Care (VBR)** is a healthcare reimbursement approach that holds providers accountable for delivering high-quality, coordinated, and cost-efficient care and improving health outcomes.
- **Alternative Payment Models (APM)**, often used interchangeably with VBR, are healthcare payment arrangements that incentivize providers to deliver high-quality, coordinated, and cost-efficient care, often with the goal of reaching value-based care. There are many forms of APMs, ranging from bonus payments to full capitation, with varying levels of risk and reward that they present to healthcare providers, and they can be applied to a specific clinical condition, a care episode, or a population.
- **Health Outcomes** measure the impact of a health intervention (e.g., treatment) on patients or a group of patients, also called a population.
- **Quality Measures** are tools that help us measure the performance of health plans and providers in delivering care and improving health outcomes.

SAPC 10-Year Payment Reform Roadmap

Purpose:

1. To provide a ***living*** roadmap for SAPC's payment reform approach, inclusive of its rate structure and capacity-building and incentive funds
2. To steer and shape the practice of its provider network, as well as to strengthen necessary system infrastructure, all with the aim of moving its network to a more value-based care model.

Goal: To improve the quality of care for people with SUDs while balancing quality, equitable outcomes, and costs.

Approach: A 10-year, phased implementation that carefully and progressively layers alternative payment strategies into the current FFS structure, ultimately arriving at value-based care or a similar approach.

Phase 1		Phase 2		Phase 3		Phase 4		Phase 5	
Investing in the Foundation		**Implementing Outcome-Focused Reforms**		**Delivering Quality + Value**		**Managing Risks + Rewards**		**Operating in a Value-Based or Population Health Environment**	
2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33

Fee-for-Service → **Value-Based Care**

SAPC 10-Year Payment Reform Roadmap

This roadmap uses a **“Recommended-Encouraged-Required”** approach to conceptualize the evolution of key system changes toward payment reform.

Recommended = Capacity Building **Encouraged** = Incentives **Required** = Contracts & Compliance

SAPC’s Considerations in its Payment Reform Roadmap

- For **rate structure**, how do we carefully move toward value-based care while balancing our system and provider network’s adoption needs?
- For **capacity building**, what investments are needed to support the introduction and expansion of alternative payment strategies?
- For **incentives**, what quality and performance measures are important to our system’s goals and priorities?

SAPC 10-Year Payment Reform Roadmap

	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5	
	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33
Rates Structure	FFS		FFS + narrow alternative payment strategies		FFS + expanded alternative payment strategies		FFS + expanded alternative payment strategies tied to quality and other measures		Value-based care or population-based alternative payment model	
Capacity Building	SUD counselors + LPHA + R95 + foundational business operations		LPHA + MAT prescribers + access to care (including R95) + developing performance/risk metrics + assessing organizational risk + care coordination		Workforce sustainability + managing risks + care redesign in VBC + patient experience + balancing quality and cost		Internal performance metric monitoring + managing upfront, predictable payments		Fiscal/business operational needs	
Incentives	SUD counselors + LPHA + access to care (R95) + enhancing data reporting		SUD counselors + LPHA + access to care (R95) + quality care + enhancing data reporting		Incentives as care and cost benchmarks/ expectations		Incentives as care and cost benchmarks/ expectations		Incentives as care and cost benchmarks/ expectations	

Capacity Building payments become a smaller portion of our CB&I investments over time.

Incentive payments become a larger portion of our Capacity Building and Incentive investments over time.

COUNTY OF LOS ANGELES
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BH Admin Integration

BH Admin Integration

- **Why – Primary goals of BHAI**
  - To improve health care outcomes and the experience of care for Medi-Cal beneficiaries—particularly those living with co-occurring mental health and SUD issues.
  - To reduce administrative burden for beneficiaries, counties, providers, and the State.

- **What – BHAI aims to achieve these goals by moving county BH services into a single, integrated contract between counties and the State (DHCS) for specialty MH and SUD services**
  - Two systems under one contract between DHCS and counties
    - The specialty MH system and specialty SUD system will remain separate and distinct (different billing systems and policies), although there will be a single contract with the State for these two distinct systems with BHAI
  - DHCS states in their BHAI Concept Paper that counties where specialty MH and SUD systems are in different Depts (LAC) do NOT need to change their Departmental structures
    - **LA County is NOT required to merge SAPC with DMH as a result of BHAI**

BH Admin Integration (cont'd)

- **What – BHAI is comprised of 11 components**

Streamlining Beneficiary Experience	Integrating County Structures & Processes	Integrating DHCS Oversight Functions
1. Integrated 24/7 Call Center	4. Integrated DHCS-County Contract	8. External Quality Reviews
2. Screening, Assessment & Treatment Planning	5. Data Sharing & Privacy	9. DHCS Compliance Reviews
3. Beneficiary Materials, Appeals & Grievances	6. Cultural Competence Plans	10. Network Adequacy
	7. Quality Improvement Plans	11. Provider Oversight

1. Integrated Call Center

- SAPC's Substance Abuse Service Helpline (SASH) will be integrated with DMH's ACCESS Center to form a single call center for people calling for specialty SUD and/or MH services

2. Screening, Assessment, & Treatment Planning

- Only applies to DMH given that specialty MH services (moderate – severe) are carved out from the non-specialty MH services (mild– moderate) that the managed care plans (MCP) are responsible for.
- This component focuses on clarifying/simplifying this interface between specialty MH plans and MCPs

BH Admin Integration (cont'd)

- **What – BHAI is comprised of 11 components** (cont'd)

3. Beneficiary Materials, Appeals & Grievances

- Integrated client-facing materials (brochures, etc) and appeals and grievance processes

4. Integrated DHCS-County Contract

- Single contract between LAC and DHCS for specialty MH and SUD service

5. Data Sharing & Privacy

- Enhanced data exchange within and between specialty SUD and MH plans, as well as with MCPs, in compliance with applicable confidentiality regulations (42 CFR Part 2, HIPAA, etc)

6. Cultural Competence Plans (CCP)

- Integrated CCP that establish plans for prioritizing cultural competency across the specialty SUD and MH plans

7. Quality Improvement Plans (QIP)

- Integrated QIP that establish plans for improving quality across the specialty SUD and MH plans

BH Admin Integration (cont'd)

- **What – BHAI is comprised of 11 components**

8. External Quality Reviews

- Integrated process for third-party external quality reviews (similar to public health accreditation process) across the specialty SUD and MH plans

9. DHCS Compliance Reviews*

- Integrated DHCS compliance reviews of the specialty SUD and MH plans

10. Network Adequacy

- Integrated network adequacy certification process by DHCS of specialty SUD and MH services

11. Provider Oversight*

- DHCS is considering how it can better align licensing and certification processes across the separate specialty SUD and MH systems

*** DHCS will need to provide guidance to counties to proceed with BHAI planning for these components**

BH Admin Integration (cont'd)

- **When – DHCS has set a phased timeline for BHAI implementation**
  - **Phase 1:** CY 2023 - 2024
  - **Phase 2:** CY 2025 - 2026
  - **Phase 3:** CY 2027+
    - Phases 1 and 2 are voluntary and DHCS' Concept Paper outlines steps counties can take within these Phases to work toward completion of the various BHAI components
    - The single State-County contract for specialty SUD and MH services is envisioned to be completed by Phase 3 (2027+)

Important Considerations Related to BH Care Integration

CalAIM already allows specialty MH and SUD services to be reimbursable across both systems

- **BHIN 21-073**: Clarified that while a diagnosis is needed (e.g., "unspecified" or Z codes), a SUD diagnosis is not a prerequisite for access to covered DMC-ODS services and a MH diagnosis is not a prerequisite for access to covered specialty MH services.
- **BHIN 22-011**: Clarified that clinically appropriate and covered DMC-ODS services are covered Medi-Cal services whether or not the beneficiary has a co-occurring MH condition. The same is true for specialty MH services.
- **BHIN 22-019**: Clarified that services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether specialty SUD or MH access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria are covered Medi-Cal services whether or not the beneficiary has a co-occurring or MH services.

  - **As long as there is documentation to support how treating a MH diagnoses will also benefit someone's SUD condition, DMC-ODS providers can deliver MH services and be reimbursed through DMC-ODS. Similarly, specialty MH providers could deliver SUD services and be reimbursed through the specialty MH system provided documentation that those SUD services benefit someone's specialty MH condition.**
  - **This is an example of how reimbursable integrated behavioral health services can be provided within our current Medi-Cal specialty systems.**

Important Considerations Related to BH Care Integration (cont'd)

As a result of the new BH Information Notices (BHIN) from DHCS under new CalAIM policies, BH care integration is already possible today, even without BHAI

- BHAI is not needed to achieve client-level BH care integration
- Other barriers to BH care integration currently exist that are preventing BH care integration (workforce factors, cultural factors, organizational factors, etc).

RAND analysis looking at the evidence to support how administratively integrating systems through "carve-ins" found:[1]

- Evidence on the benefits of carve-in models is surprisingly limited
- Carve-in does not necessarily result in financial, organizational, or clinical integration, or expected outcomes.
- **Whether administrative structures are carved-in or carved-out, additional interventions are needed in either case to achieve clinical integration and desired outcomes.**
- **The expected benefits of carve-in models can be achieved in a carve-out environment**
  - Carve-in and carve-out models can have comparable performance if designed to facilitate desired outcomes

1. https://www.rand.org/pubs/research_reports/RRA1517-1.html

Los Angeles County's Approach to BHAI

- **In 2008, there was an analysis exploring the merger of ADP (former name of SAPC) and DMH and the conclusion was that the benefits of ensuring a dedicated SUD focus outweighed any potential benefits of a merger.**

- **April 18, 2023 Board Motion (SD3 & SD5)**
  - Directed DMH and SAPC to report back in 120 days and bi-annually thereafter with status updates on BHAI work
  - Directed CEO, in collaboration with DMH and SAPC, to retain a consultant to provide recommendations and options for the County to provide more integrated and comprehensive care for individuals suffering from co-occurring disorders, including recommendations for any additional resources or authorities needed to further integrate specialty MH and SUD administration and services.
    - **KPMG is consultant selected by CEO**
      - CEO Budget is the project manager for BHAI Board motion
      - KPMG performed stakeholder interviews around BHAI, including with other counties
      - KPMG is planning on releasing report to BOS in August

SAPC's Work-In-Progress

Key Principles

1. We cannot achieve a robust BH system without a robust SUD system → prioritizing the ongoing growth and support of the specialty SUD system is essential and lacking in most counties today
2. On-the-ground, client-level BH care integration must be the driving force behind implementation of BH Admin Integration

SAPC is working closely with DMH to implement BHAI

- Steering Committee with DMH and SAPC leadership
- Workgroups focusing on 11 BHAI components
  - Initial focuses:
    - Call center integration
    - Quality Improvement Plan integration
    - Cultural Competency Plan integration
    - Initiation of data sharing work (this will be very complex)

Prop 1 – "Behavioral Health Transformation"

Prop 1

- **Prop 1 was a major priority for the Newsom Administration and was narrowly passed by voters (50.1% to 49.8%) in March 2024**
  - **2 key components**
    - **"MHSA Modernization" (SB 326)**
      - MHSA (aka: Prop 63) is the 1% tax on personal income >$1M in CA to fund the specialty MH system; comprises ~25% of overall specialty MH funding
      - MHSA has traditionally not been used for specialty SUD systems
    - **$6.4B bond measure (AB 531)** to invest in residential and supporting housing settings

Prop 1 (cont'd)

- **Key BHSA Changes**
  - **MHSA → BHSA**
    - Allows for MHSA to be used for SUD and renames it "BHSA"
    - Raises State share of BHSA from 5% to 10%:
      - 4% for population-based prevention for CDPH
      - 3% for statewide workforce priorities for HCAI (Health Care Access and Information; formerly OSHPD)
      - 3% for DHCS Admin (including $20M for BHSOAC [BH Services Oversight & Accountability Commission])
    - Requires 30% of MHSA to be spent on housing (will trigger financial shifts by DMH to avoid reductions in outpatient service and prevention investments)
  - **Planning and Reporting Requirements**
    - Change from MH Commission to "**BH Commission**" with new evaluation responsibilities of specialty SUD systems as well as specialty MH systems
      - BHSA planning and outcome reporting requirements will pertain to both DMH and SAPC

Prop 1 (cont'd)

- **Key BHSA Changes**
  - **Planning and Reporting Requirements** (cont'd)
    - **Integrated Plan** for use of BHSA funds must be submitted to the BHSOAC and approved by the BOS
      - Includes a needs assessment with local data to guide local needs, including prevalence/unmet need of MH and SUDs, disparity data, homeless point in time count → data must demonstrate how the Integrated Plan appropriately allocates funding between MH and SUD services
      - The Integrated Plan shall consider the needs assessment of the Medi-Cal managed care plans, the Community Health Improvement Plan (CHIP), and include the five most populous cities – Los Angeles, Long Beach, Santa Clarita, Glendale, and Lancaster
      - Must include budget of programs for all funding sources received by DMH and SAPC, including those outside of BHSA (SAMHSA block grants, opioid settlements, etc).
      - New authorities under Prop 1 → DHCS may require revisions to the Integrated Plan, impose CAPs, monetary sanctions, temporarily withhold payments to counties

Prop 1 (cont'd)

- **Key BHSA Changes**
  - **Planning and Reporting Requirements** (cont'd)
    - Annual report called the **Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)** which includes, but is not limited to:
      - Annual allocation, expenditures and unspent amounts of all local, state and federal funds received by DMH and SAPC
      - Performance measures across specialty MH and SUD systems
      - Workforce metrics including vacancies, numbers of county staff performing direct services, changes in staff numbers from prior year
      - BOS will need to attest the BHOATR is complete and accurate before submission to DHCS

Translating Terminology Changes Into Action

- "Behavioral Health (BH)" = Mental Health (MH) + Substance Use Disorders (SUD)
- Mental Health Services Act (MHSA) → Behavioral Health Services Act (BHSA)

- Similar to how LAC leads county specialty SUD systems across the State because of its unique structure that allows for a dedicated focus on SUD priorities and has supported unprecedented growth of its SUD system, LAC has an opportunity to lead the State in its approach to Prop 1.
- BH care integration does not happen with structural changes alone or by default → an integrated BHSA vision will require additional coordination and work beyond the status quo.

Opportunities for LAC to Lead the State in Prop 1 Implementation

- **BIG PICTURE → Ensuring that the BH in BHSA is meaningful in both words and action (focuses on both SUD and MH priorities)**
  - The Interim Housing Outreach Program (IHOP) is a great first start and example.

- **Representation & Focus → Ensuring true coordination across new BHSA infrastructure and processes to support both SUD and MH priorities**
  - BH Commission
  - Integrated Plan development process, including the budget and programming for SUD funds
  - Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) – expenditures, underspending, performance metrics

Opportunities for LAC to Lead the State in Prop 1 Implementation (cont'd)

- **BHSA Housing Investments → Recovery-oriented housing**
  - LAC has been unique in the extent SAPC has invested in recovery-oriented housing across the County.
  - Increased housing investments under BHSA represent an opportunity to further differentiate LAC's approach to homelessness to ensure a continuum of housing options.

- **Prevention → Opportunities outside of BHSA**
  - LAC is unique in terms of SAPC's investments in Prevention, investing more than double the amount that most counties use in their federal Substance Use Block Grant funds to support upstream Prevention, particularly around Positive Youth Development.
  - The importance of upstream investments must not be lost.

Opportunities for LAC to Lead the State in Prop 1 Implementation (cont'd)

- **BHSA Bond Investments → SUD capacity**
  - Similar to the BH Continuum Infrastructure Program (BHCIP), SAPC aims to ensure that the bond funds under BHSA are invested to expand BH capacity, inclusive of SUD capacity

COUNTY OF LOS ANGELES
Public Health

Summary

LA County's Unique BH Structure

- ***Known*** **(+)'s of LAC's current BH structure**
  – Dedicated focus, leadership, and staff to advance SUD priorities
  – Dedicated budget that allows for SUD investments unique compared to other counties
  – Unlike DMH, SAPC has open and continuous contracting which has allowed it to expand services across its continuum (Prevention, harm reduction, Treatment) in ways that are unique compared to other counties
  – SAPC's leadership team is a recognized statewide leader and SUD is represented on various statewide behavioral health Commissions as a result of SAPC and LAC's structure
    - California HHS' BH Task Force (led by Secretary Ghaly)
    - DHCS' BH Transformation (Prop 1) Workgroup
    - DHCS' BH Stakeholder Advisory Committee
    - DHCS' CalAIM Data Sharing Advisory Group
    - County Behavioral Health Directors Association (CBHDA) Governing Board

    SAPC is the only county SUD representative on all of these groups; other county reps generally do not have much familiarity with SUD priorities and rarely raise SUD priorities… A merger of SAPC with DMH would have statewide implications
  – While not perfect, SAPC's operations and responsiveness to issues have generally been viewed positively by County leadership and providers
    - How would merging SAPC with DMH enhance/improve the SUD system?
  – SAPC's provider network prefers having a dedicated focus on the SUD system

LA County's Unique BH Structure (cont'd)

- ***Potential*** **(-)'s of LAC's current BH structure**
  - Adverse impacts on client-level BH care integration (though this is already currently possible per new CalAIM policies)
  - Challenges leveraging economies of scale (though economies of scale have not favored SUD systems in counties with integrated BH Depts)
  - Theoretical ability for the specialty MH system to financially support the SUD system (though the fiscal impacts of Prop 1 and historical budgetary decisions by BH Depts across the state make this unlikely, especially in the near term)

LA County's Unique BH Structure (cont'd)

- **Fundamentally, LAC's unique BH structure positions it well for BH care integration for the following reasons:**
  - LAC's current structure promotes dedication to and elevation of SUD priorities in ways that are unique compared to other counties
  - SUD leadership in LA is able to represent the full operational perspective (financial, contractual, etc) of its SUD system, unlike in other counties
  - SUD systems are under-developed and require catch-up… Integrating under-developed SUD systems with more fully-developed MH systems poorly positions SUD systems for success and ongoing investment
  - The SUD perspective would not be represented in most statewide Committees/Commissions/Workgroups without SAPC's autonomy within LAC's unique BH structure
  - A strong SUD system is a prerequisite of a strong BH system, and LAC's unique BH structure facilitates investments of time, energy, and resources in the specialty SUD system