Preparing for Value-Based Care in the Specialty SUD Treatment System

Division of Substance Abuse Prevention and Control (SAPC)

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.