



# **Health Care Reform In California's SUD Treatment System**

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# 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
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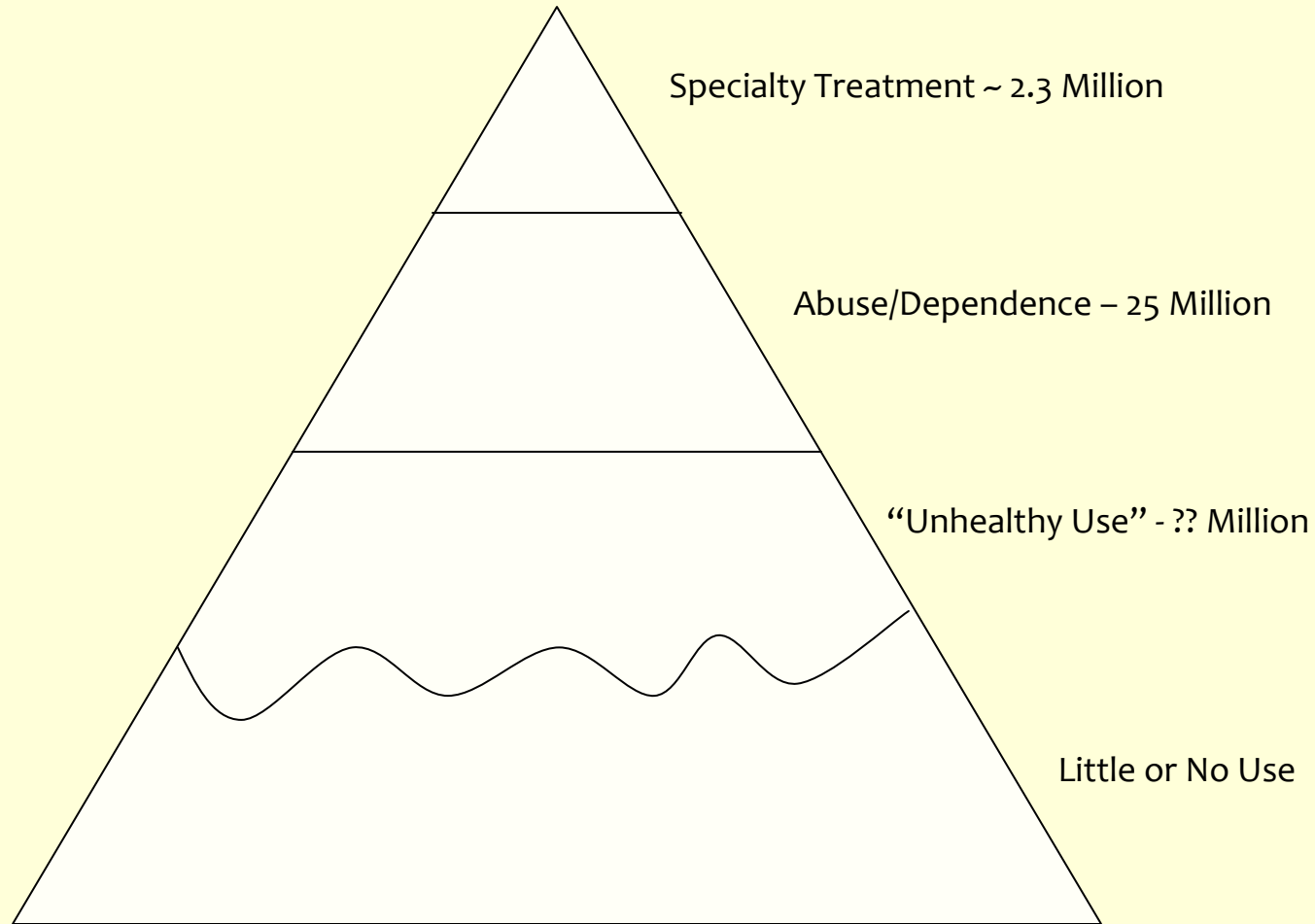
# National Drug Control Strategy for FFY 2011

- \$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
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# 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.
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# Population Segments in the National Drug Control Strategy



# Parity

- Group health plans must provide MH and SU benefits at parity with medical/surgical benefits with respect to financial requirements and treatment limitations.
  - Parity is defined with regard to scope of services, medical management and financial requirements.
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# 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
    - Regulations need to be issued by CMS
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# Health Care Reform

- SUD services a “Essential Health Benefit”; a component of benchmark plans.
  - Coverage Expansion
    - 133% FPL = an additional ~ 2,700,000 uninsured persons aged 19 – 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
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# 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.
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# 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.*
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# 1115 Waiver

- Broad discretion in the design of BHI pilots.
    - Counties provide match to FFP
    - No risk to state
  - The focus is on the Coverage Initiative counties – the current 10 (which include CC) as well as expansion counties.
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# 1115 Waiver

- Importance of waiver
    - Establish a model for a new MC benefits for SUD
    - 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.
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# What about Prevention?

- Prevention in health care is very different.
    - Smoking cessation
    - Diet & Exercise
    - Self management
    - Also promotion of wellness
  - The question will be prevention of What?
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# What about Prevention?

- The IOM framework may be the model.
    - Universal – More or less what we do now.
      - Coalitions, Education, Environmental
    - Selective – Early intervention for high risk subpopulations – children of SUD Tx clients.
    - Indicated – Targets individuals exhibiting early signs of SUD – SBIRT, Student Assistance Programs.
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# 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 in California take to find its way?
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# 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.
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# 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 SUD 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.
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# Changing Roles and Relationships

- HCR will change relationships between county AOD Administrators and providers as networks of specialty care are developed.
  - Small programs and 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?
    - Primary funder may be CCHP and not ADP.
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# Laying the Groundwork

- AODS working to engage and develop relationships with the local health care system
    - County health system
      - The 1115 Waiver may be the first step
    - FQHC's
      - Also HSD and La Clinica de la Raza
    - Medi-Cal managed care plans
      - CCHP and Anthem Blue Cross
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# Laying the Groundwork

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

Study capacity building needs in your agency.

- Organizational (e.g., develop a strategic plan for HCR; develop Medi-Cal claiming capacity)
  - Adoption of Evidence Based Practices
  - Information Technology
  - Workforce
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# Readiness Assessment - Providers

- Are providers 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. Are providers willing to serve non-traditional SUD populations (e.g., heavy users without an abuse/dependence diagnosis) or work towards outcomes other than sobriety?
  - How many are DMC certified?
  - How many licensed staff?
  - Do providers have a medical director, medical consultant, or psychiatric support?
  - Are any accredited – e.g., 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?
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# Next Steps in Contra Costa

- Get providers DMC certified
    - Only half of California's ODF providers are certified. Only 33% actually bill DMC.
    - Work with AODS 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).
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# Next Steps in Contra Costa

- 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?
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# Next Steps in Contra Costa

- 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).
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# Next Steps in Contra Costa

- 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.
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# Next Steps in Contra Costa

- 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.
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# Next Steps in California

- Restructure DMC as an organized system of care.
  - Smaller counties might consider regionalization of back office functions.
  - ADP should expedite provider DMC certification process.
  - CADPAAC involvement in state level discussions – 1115 Waiver, Exchanges, benchmark plans.
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