



# CALIFORNIA OPIOID MAINTENANCE PROVIDERS

## Comments Regarding Payment Models for the Proposed 1115 Waiver for California’s Drug Medi-Cal Program Submitted by California Opioid Maintenance Providers.

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During the third and final meeting of the Waiver Advisory Group established by the Department of Health Care Services and Chaired by Karen Baylor, most of the discussion revolved around rate setting for the Drug Medi-Cal (DMC) program. The presentation by Don Kingdon of the County Mental Health Directors Association (CMHDA) described the current payment model for the Medi-Cal (MC) specialty mental health program for severely mentally ill (SMI) people in California. It is important to note at the outset that the rate schedules in the MC specialty mental health program are significantly higher, allow broad discretion by providers in billing for services and not constrained by the cost containment mechanisms that the DMC rates are subject to and that are discussed below.

The California Opioid Maintenance Providers (COMP) have been actively involved in discussions with the Department of Health Care Services (DHCS) to express strong opposition to the Department’s intent to apply for a waiver from federal rules that ensure access for (DMC) beneficiaries including freedom of choice, comparability of services, and state-wideness. COMP is also especially concerned about reverting back to a cost-reimbursement system for Narcotic Treatment Programs (NTPs), as more fully described below.

### Background

Substance use disorder treatment providers generally have, for many decades, been burdened with excessive regulations and paperwork from multiple regulatory and funding entities (Carise, Love, et al, 2009). NTPs in particular have endured perhaps the greatest level of paperwork burden given the additional regulatory oversight due to stigma and administration of Schedule II narcotics to treat opiate addiction. These excessive burdens do not result in improved patient outcomes or cost-containment but rather wasteful use of scarce resources.

NTPs provide a critical, life-saving service that has been unequivocally proven to reduce drug use, criminal activity and mortality while improving social productivity. As a result, in 1997, the California legislature adopted Assembly Bill 2071 to codify “the intent of the Legislature that the department [of Alcohol and Drug programs]... eliminate unnecessary costs for narcotic treatment programs.”

The primary accomplishment of that law resulted in converting narcotic treatment programs certified as DMC providers from an antiquated cost-reimbursement model to a fee-for-service model. This fee-for-service payment model aligned provider payments with performance measures that are scientifically-proven to improve clinical outcomes. Specifically, the legislature created two units of service for which NTPs could charge the DMC program: a dosing unit and a counseling unit. All of the research on methadone treatment demonstrates that daily medication adherence and regular counseling result in improved outcomes (Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol 43, 2005). Thus, with the current fee-for-service model for NTPs, providers are paid for delivering services that yield the best possible results and not paid for anything else not related to performance. This approach is perfectly aligned with the triple aim of the Affordable Care Act: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

### **Current Cost-Containment Systems**

At the same time, there are three tiers of cost containment built-into the current fee-for-service system, as follows:

#### **Tier One Cost Containment Mechanisms**

- The dispensing rate is derived from a complicated formula based on objective data such as CPT codes, state salaries and actual costs for lab tests – all of which are individually contained through their respective development processes such as the state budget or competitive market forces. Notably, the state salaries have never changed since the inception of the formula in 1997. For example, the MD rate used by the formula is the state’s “Range A, Step 1” which pays just over half what it actually costs to hire a qualified, experienced physician in our field today; and
- The counseling rate is based on cost report data that is at least two years old. Thus, rates developed for FY 2014-2015 are based on the cost to deliver services in 2010-2011, four years out-of-date.

#### **Tier Two Cost Containment Mechanism**

- Section 14021(b) of the Welfare and Institutions Code, which was inserted during the fiscal 2009-2010 budget process, not only cut rates by 10%, but also created an artificially low baseline to which the Implicit Price Deflator would be applied for all future years. This has the effect of making permanent a rate decrease that was described as a one-time reduction.

#### **Tier Three Cost Containment Mechanism**

- Finally, the trailer bill language adopted in 2009 requires that the reimbursement rates to providers be the lesser of the 2009-2010 rates plus the Implicit Price Deflator adjustment or the “developed rates” calculated using the formula based on objective costs, thus mandating the lowest possible reimbursement to providers.

In summary, these three cumulative tiers of cost containment result in reimbursement that is controlled at multiple levels.

### **Problems with Cost Reimbursement**

Cost reimbursement is an inferior payment model as compared to fee-for-service because it wastes scarce resources at the provider, county and state level, fails to reward provider performance and provides incentives for providers to increase costs and to be inefficient.

Waste occurs when providers must complete time-consuming cost reports, counties must allocate resources to review and reconcile those reports, and then the state must also allocate resources to review, reconcile and settle costs. In this model, costs are often not settled for up to seven years from the date of service, requiring extreme accounting measures that drive more costs and expose counties and the state to the inability to recoup improperly spent funds.

Cost-reimbursement also encourages inefficiency as providers add unnecessary staff in order to provide more services than is required for best-practice care. Moreover, given that providers charge an indirect fee based on cost, they have incentive to grow costs to drive greater indirect fees. In short, cost-reimbursement simply responds to provider cost increases by increasing reimbursement.

Finally, cost-reimbursement is unable to reward provider performance or even recognize clinical outcomes.

On the other hand, the current fee-for-service model for NTPs pays only for actual services delivered to beneficiaries and provides incentives for evidence-based practices that improve outcomes.

There is broad consensus among stakeholders in California that the current cost-reimbursement system for non-NTP DMC programs fails to adequately compensate providers for the highly technical task of treating the complex disease of addiction and its myriad ramifications. As with many of DHCS' other goals, improving the reimbursement system for non-NTP providers can be accomplished through a State Plan Amendment or statutory changes and does not require a waiver of federal law that will diminish quality and reduce efficiency.

In summary, forcing all NTP providers to complete the onerous task of cost reporting and paying providers in a cost-reimbursement model will result in payment for services not aligned with evidence-based practices, wasteful use of scarce resources and, worst of all, substandard outcomes for beneficiaries. We suggest DHCS instead submit a State Plan Amendment to change all DMC providers to fee-for-service, modeled after the current NTP methodology and align billing units with performance measures that are evidence-based best practices.

Thank you for your attention to this matter. COMP requests that this response be included in any written documents summarizing the stakeholder process.