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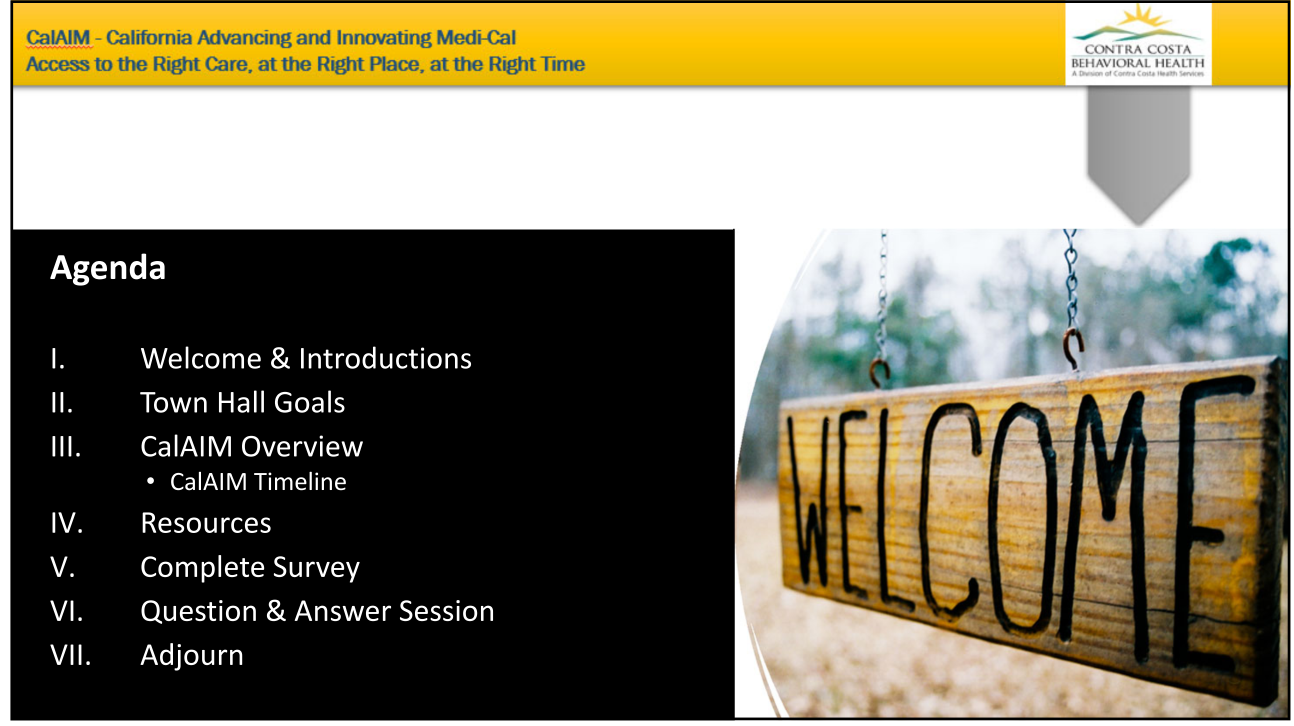

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Town Hall Goals

1. Understand primary goals of CalAIM.
2. Create readiness for go-live.
3. Orient individuals to what will be included in CalAIM implementation.
4. Learn where to find resources.
5. Complete Survey.

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Glossary

- AOD: Alcohol and Other Drugs
- ASAM: American Society of Addiction Medicine
- CalAIM: California Advancing and Innovating Medi-Cal
- CANS: Child and Adolescent Needs and Strengths
- Co-Occurring Capable – able to treat both MH and SUD
- CPT: Current Procedural Terminology
- DHCS: Department of Health Care Services
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- ICC: Intensive Care Coordination
- ICD: International Classification of Disease
- LPHA: Licensed Practitioner of Healing Arts
- MAT: Medication Assisted Treatment
- MCP: Managed Care Plan
- MH: Mental Health
- MHP: Mental Health Plan
- NSMHS: Non-Specialty Mental Health Services
- SMHS: Specialty Mental Health Services
- SUD: Substance Use Disorder add text

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Guiding Principles of CalAIM

- CalAIM is moving Medi-Cal towards a population health approach that **prioritizes prevention** and **whole person care.**
- The goal is to **extend supports and services beyond hospitals and health care settings** directly into California communities.
- The vision is to **meet people where they are** in life, **address social drivers** of health, and **break down the walls** of health care.
- CalAIM will offer Medi-Cal enrollees **coordinated and equitable access to services** that address their **physical, behavioral, development, dental and long-term care needs**, throughout their lives, from birth to a dignified end of life.

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Primary Goals of CalAIM

Manage Risk

- Through whole person care approaches and addressing Social Determinants of Health (SDOH)

Reduce Complexity

- Move Medi-Cal to a more consistent and seamless system and increasing flexibility

Improve Outcomes

- Reduce health disparities, and drive delivery system transformation and innovation

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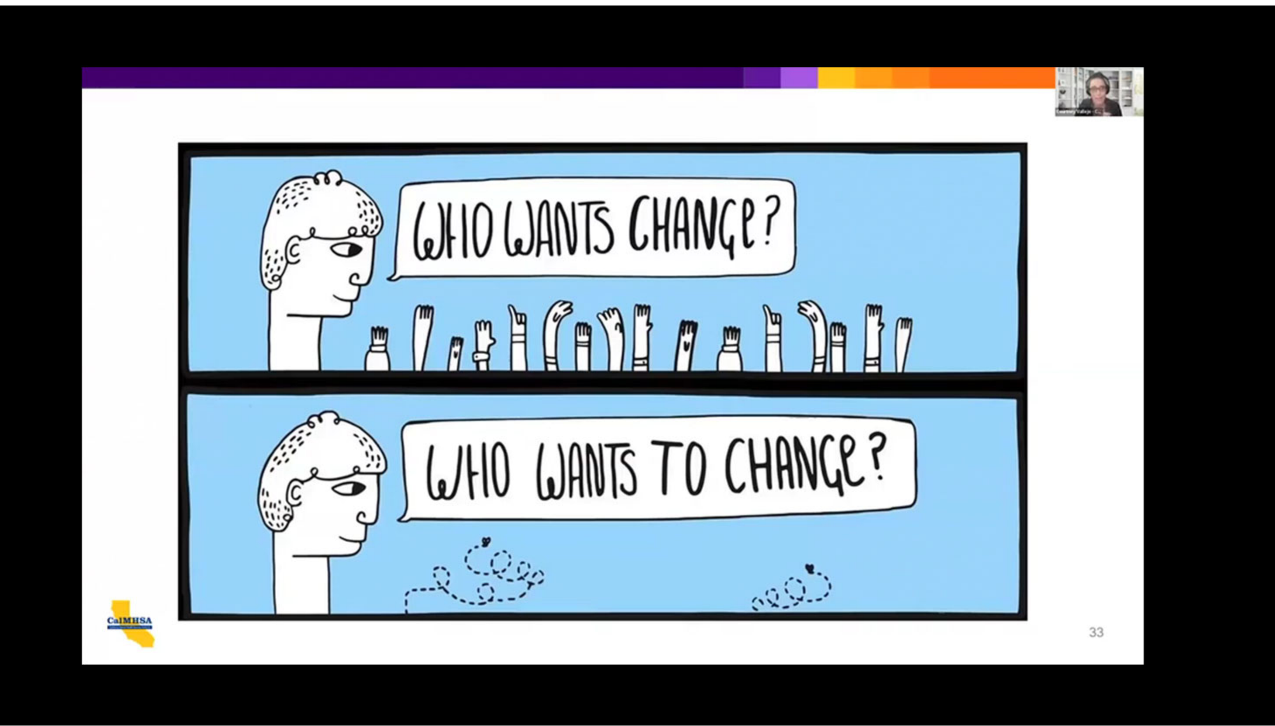

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Implementation of CalAIM

- Documentation - standardize and streamline
- Focus will be on Quality with recoupments resulting from **fraud, waste and abuse**
- Specialty Mental Health Services (SMHS) – definition broadened
- Changes to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements
- No Wrong Door
- Most Treatment Plans replaced with a Problem List

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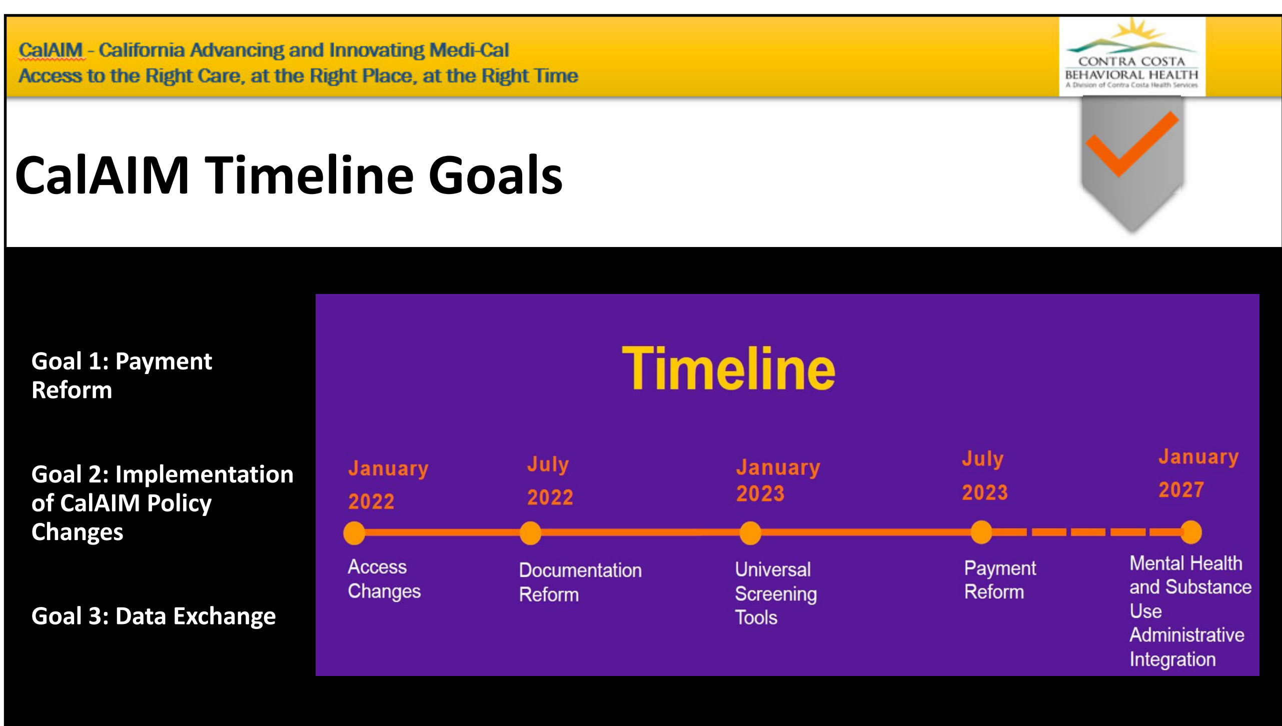

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CONTRA COSTA BEHAVIORAL HEALTH

No Wrong Door

Behavioral Health Information Notice 22-011

- Beneficiaries receive **timely** services from any entry point
- **No delay, no interruption** in treatment regardless of delivery system
- Beneficiaries may receive Non-Specialty Mental Health & Specialty Mental Health services **concurrently** if:
  - Clinically appropriate
  - Coordinated
  - Not duplicative
- **Freedom of choice**: Beneficiaries with an established therapeutic relationship may continue to receive services, even if simultaneously. Requires coordination between Managed Care Plans (MCP) and Mental Health Plans (MHP).
- Access criteria/**treatment prior to diagnosis**
  - A diagnosis is no longer a prerequisite for accessing needed SMHS or DMC-ODS services

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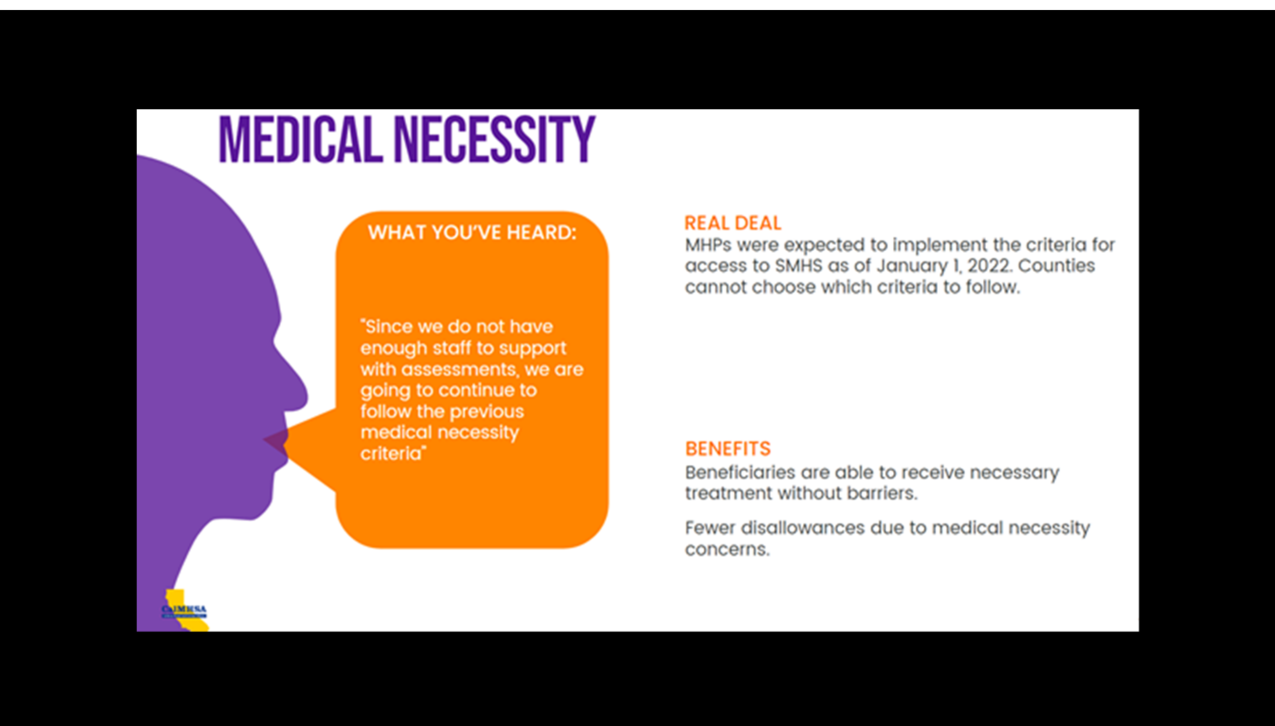

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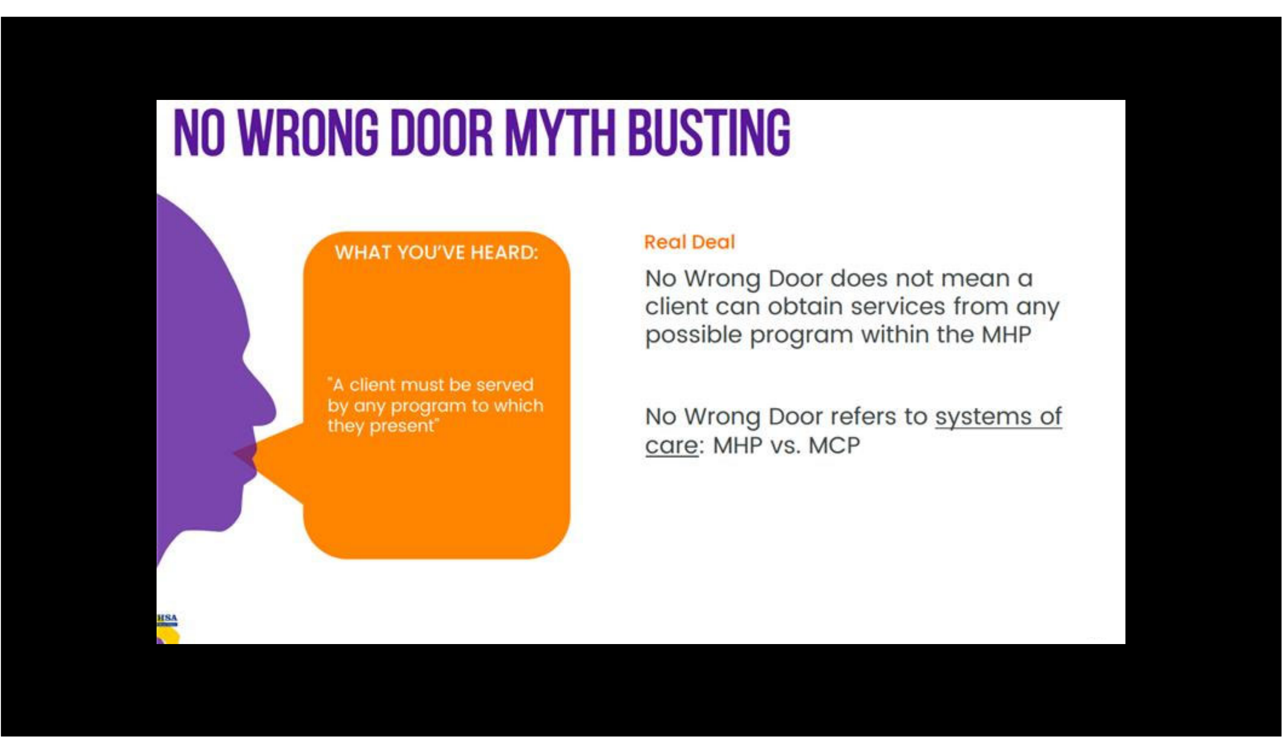

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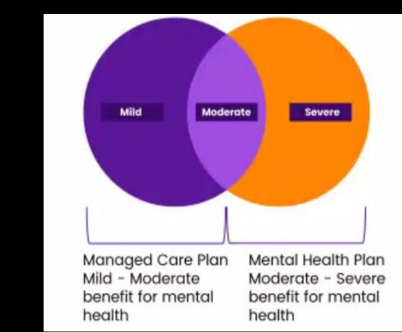
No Wrong Door

Behavioral Health Information Notice 22-011

- **Universal Screening Tool**
  - To be released in January 2023
  - Will provide guidance to MHPs and MCPs regarding the most appropriate system of care for an individual seeking mental health services
- **Transitions of Care**: Decisions via patient-centered decision-making process
  - Universal Transition Tool
    - To be released in January 2023
    - Will support more effective and coordinated transitions between systems of care



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Co-Occurring Treatment

Policy Then	Policy as of July 1, 2022	Benefit
• Services would be disallowed if a co-occurring condition was as part of the individual's treatment • Confusing experience for individuals seeking services • Fiscal implications	• Co-Occurring Treatment allows for treatment to begin "through any door" regardless of co-occurring diagnoses that may be present • Treatment in the presence of a co-occurring disorder is reimbursable	• Individuals experience streamlined process for obtaining services • Providers can take time to assess the needs of the individual • Fewer services disallowed

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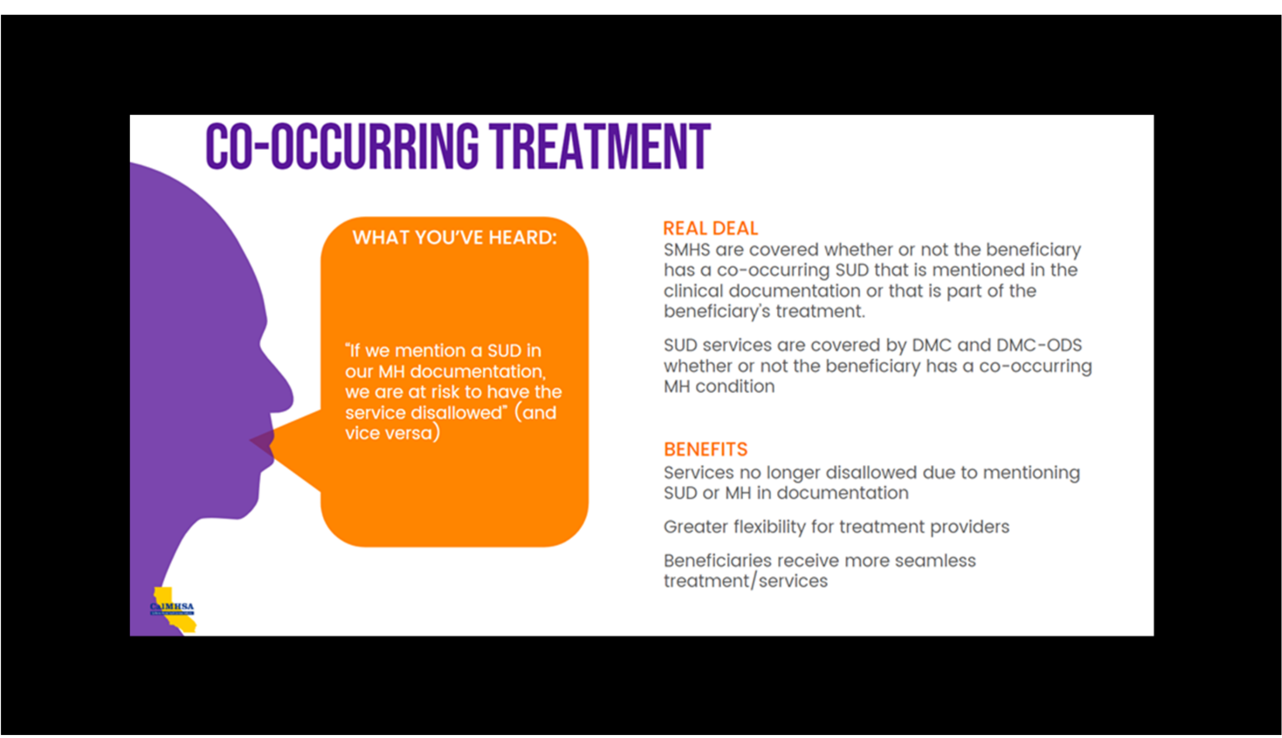

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Documentation Reform

Policy Then	Policy as of July 1, 2022	Benefit
Lengthy documentation requirements: • Stringent requirements for clinical documents • "Treating chart instead of the individual" to avoid disallowances • Provider spending more time on documentation than on treating individuals	Lean documentation: • Streamlined standards • Improved efficiency	• Less time documenting • More time to focus on direct services • Decreased provider burnout

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Documentation Reform (continued)

Policy Then	Policy as of July 1, 2022	Benefit
Static treatment plans: • Complex content requirements • Strict signature requirements • Firm due dates/renewal dates • Recoupments for services provided under an incomplete/expired treatment plan	Most treatment plan replaced by dynamic problem list: • Treatment plan still required for the following: ✓ Targeted Case Management (TCM) ✓ Intensive Care Coordination (ICC) ✓ Peer Support Services ✓ Intensive Home Based Services (IHBS) ✓ Therapeutic Foster Care (TFC) ✓ Therapeutic Behavioral Services (TBS) ✓ Narcotic Treatment Program (NTP)	• Less time spent on unnecessary documents • Simplified internal auditing processes • Decrease in unnecessary recoupments

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Documentation Reform (continued)

Policy Then	Policy as of July 1, 2022	Benefit
Disallowances for quality problems: • Excessive processes to avoid recoupments • "Treating chart instead of the patient" to avoid disallowances • Provider spending more time on documentation than treating	Disallowances focused on fraud, waste, abuse Corrective action plans for quality	• Decrease in unnecessary recoupments • Decreased provider burnout

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Documentation Reform - Changes for Providers

Behavioral Health Information Notice 22-019

DMC-ODS Assessment

- Assessment remains ASAM Criteria based
- Services (***except residential***) are reimbursable for:
  - 30 days following 1st visit even if dx not established
  - 60 days if under 21 or 21 and over and experiencing homelessness

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Documentation Redesign (cont.)

Behavioral Health Information Notice 22-019

Mental Health Assessment - From 11 Elements to 7 Domains

- **Domain 1:**
  - Presenting problem and history of presenting problem
  - Current Mental Status
  - Beneficiary-Identified Impairment(s)
- **Domain 2: Trauma**
- **Domain 3: Behavioral Health History**
- **Domain 4: Medical history, current meds, comorbidity with Behavioral Health**
- **Domain 5: Social and Life Circumstances; Culture/Religion/Spirituality**
- **Domain 6: Strengths, Risk Behaviors, and Safety Factors**
- **Domain 7:**
  - Clinical Summary and Recommendations
  - Diagnosis
  - Medical Necessity Determination/Level of Care/Access Criteria

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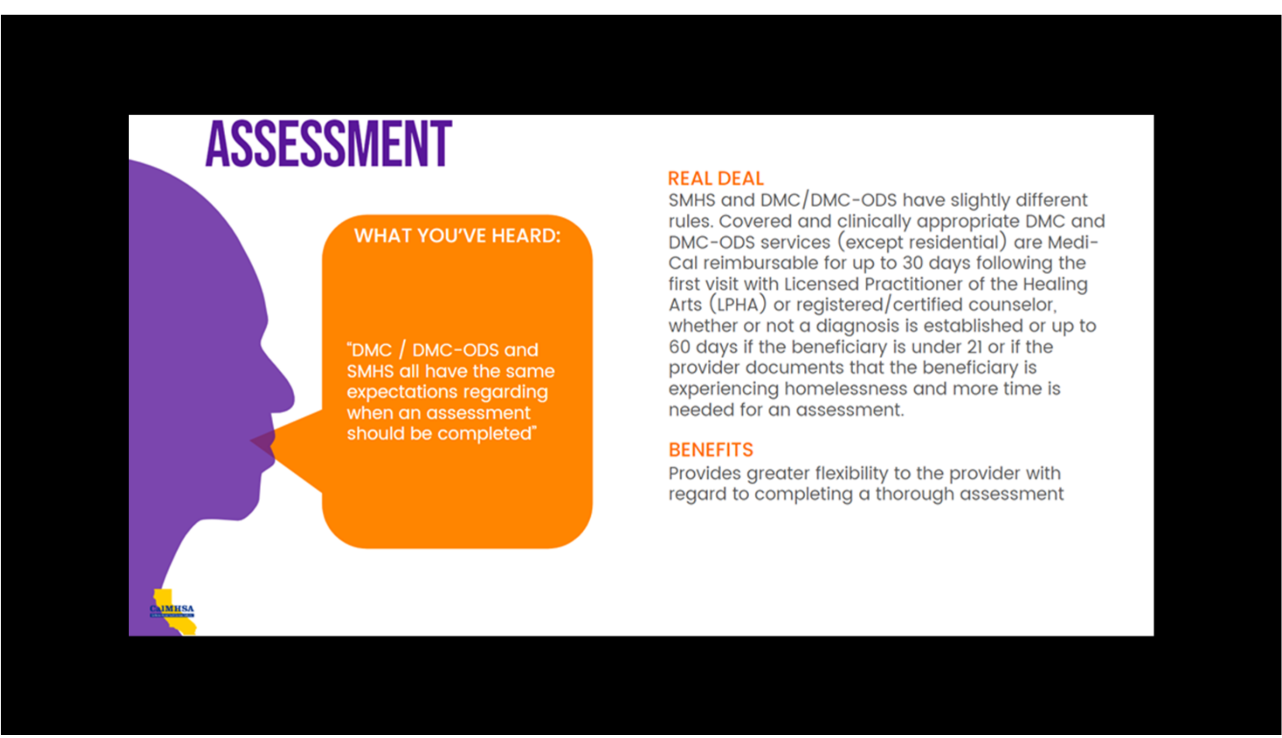

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Documentation Redesign (cont.)

Behavioral Health Information Notice 22-019

- Problem List
  - Dynamic! A Living Document
  - Looks at diagnoses, symptoms, conditions and/or risk factors
  - Problem doesn't have to live on Problem List before being treated
  - Problems can be identified by client, significant support person or provider
- Progress Notes
  - Reflect planned action steps by client or provider
  - Collaboration with the client, and/or other providers
  - Any update to the problem list, as appropriate
  - Include a place to include care plan as relevant

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Fraud, Waste and Abuse Definitions

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** includes actions that may, directly or indirectly, result in:
  - Unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.
  - Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

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What Constitutes Fraud, Waste and Abuse?

- Medicaid fraud and abuse negatively impacts health care use by wasting limited resources and potentially endangering patients through unnecessary care or preventing access to medically necessary services.
- Most providers try to work ethically, provide high-quality patient medical care, and submit proper claims.
- Most mistakes made in clinical documentation are **not** fraud, waste or abuse.
- More details to come in the DHCS 2022-2023 Annual Review Protocol (coming later in 2022).

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What is NOT Fraud, Waste and Abuse?

- Selecting the incorrect service code/CPT
- Entering incorrect service/documentation/travel time
- Billing when the client was a "no show" or the session was cancelled
- The service does not meet the definition of a SMHS
- The content of the progress note does not justify the amount of time billed
- The note that was billed is not present in the chart
- The date of service of the progress note does not match the date of the service claimed
- Documenting non reimbursable services or including mention of "non-billable" interventions during an otherwise billable note
- Service provided was not within scope of the person delivering the service
- Documentation was completed but not signed
- Group services not properly apportioned to all clients present

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What Conduct Can Raise An Inference of Fraud, Waste or Abuse?

- Repeated pattern of unnecessary services
  - Example: "assembly line" non-individualized treatment patters, or "cookie-cutter" progress notes
- Pattern of knowingly false statements on billings, or corresponding progress notes
  - Example: deliberately listing wrong location of service or provider to conceal license/eligibility issues
  - Intentional concealment of known errors or overpayments
  - Example: use of inaccurate statements, or deliberate failure to disclose adverse facts, in response to audit questions

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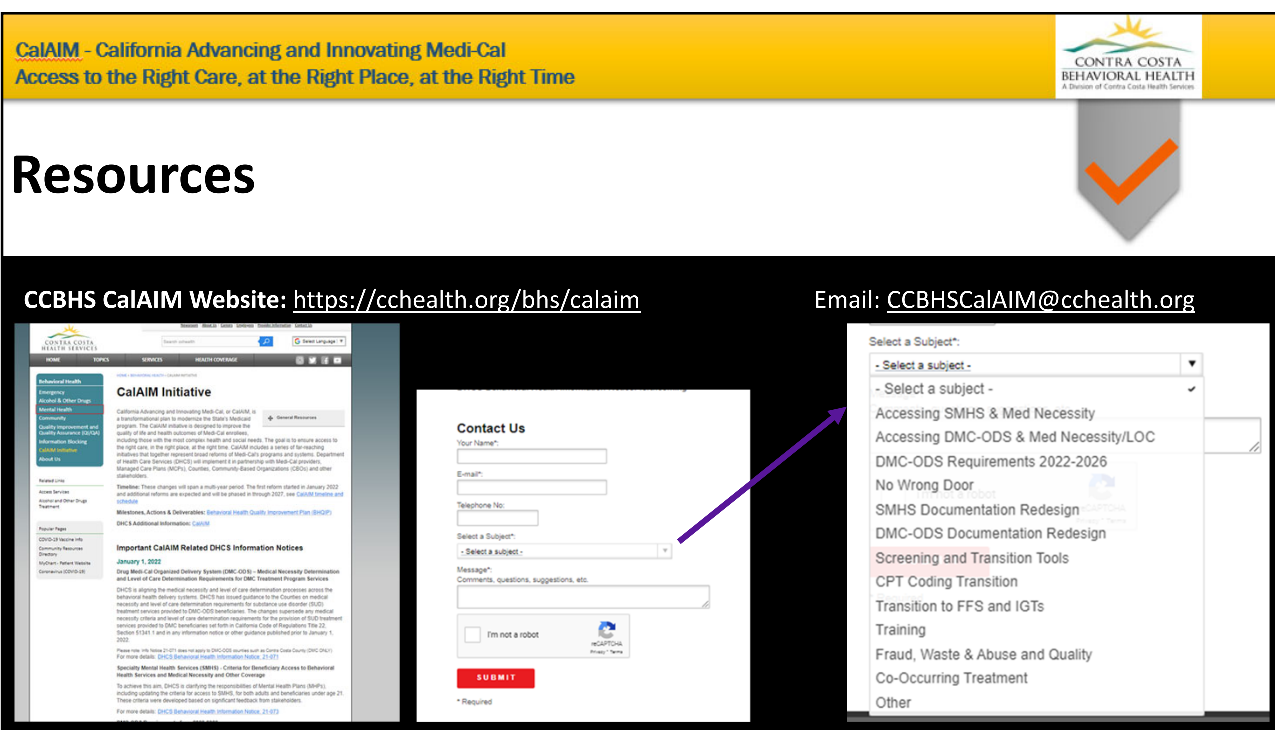

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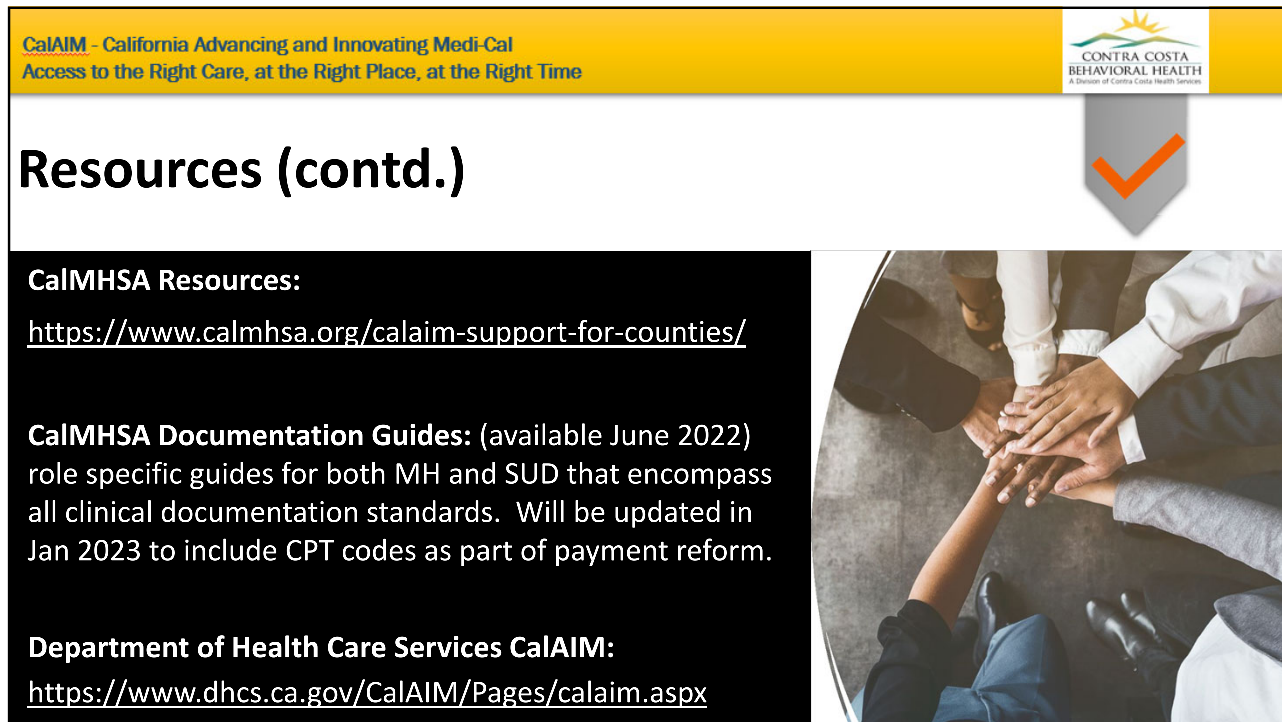

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Town Hall Survey

Please complete evaluation to verify attendance and help CCBHS gauge your understanding of information presented.

Survey link to be placed in chat.

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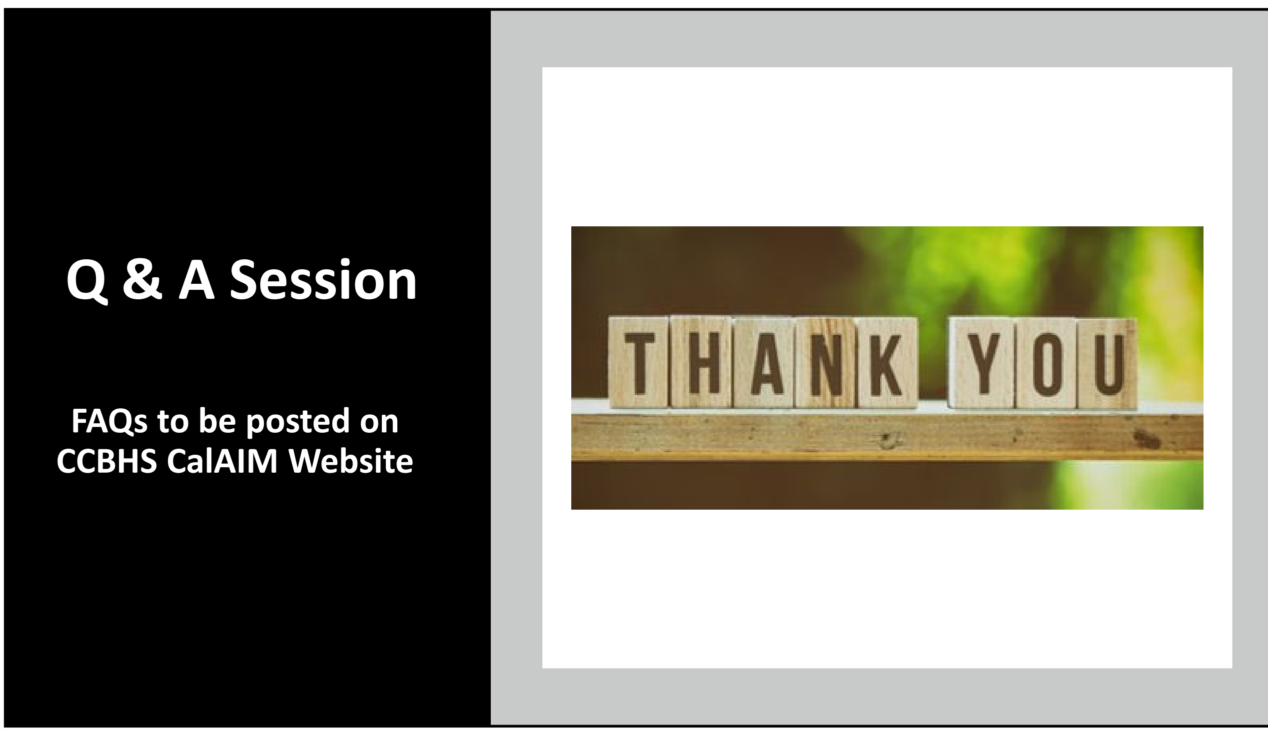

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What Happens Next?

Future Trainings / Technical Assistance (TA)

- Offered by CCBHS June 6 – 24, 2022. Dates/times TBD
- Topics include: Documentation, UR & Quality and more!

Future CalMHSA Transformation Webinars

- Available through Learning Management System (LMS)
- Counties will be able to send links to providers

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