



CONTRA COSTA
HEALTH SERVICES


Contract Provider Town Hall
5/24/22





California Advancing and Innovating Medi-Cal (CalAIM)
Overview: *Then Vs. Now*

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CalAIM - California Advancing and Innovating Medi-Cal
Access to the Right Care, at the Right Place, at the Right Time



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Agenda

- I. Welcome & Introductions
- II. Town Hall Goals
- III. CalAIM Overview
 - CalAIM Timeline
- IV. Resources
- V. Complete Survey
- VI. Question & Answer Session
- VII. Adjourn

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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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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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CalAIM Timeline Goals

Goal	Timeline Milestone	Goal Description
Goal 1: Payment Reform	January 2022	Access Changes
Goal 2: Implementation of CalAIM Policy Changes	July 2022	Documentation Reform
Goal 3: Data Exchange	January 2023	Universal Screening Tools
	July 2023	Payment Reform
	January 2027	Mental Health and Substance Use Administrative Integration

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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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MEDICAL NECESSITY

WHAT YOU'VE HEARD:

"Since we do not have enough staff to support with assessments, we are going to continue to follow the previous medical necessity criteria"

REAL DEAL
MHPs were expected to implement the criteria for access to SMHS as of January 1, 2022. Counties cannot choose which criteria to follow.

BENEFITS
Beneficiaries are able to receive necessary treatment without barriers.
Fewer disallowances due to medical necessity concerns.

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NO WRONG DOOR MYTH BUSTING

WHAT YOU'VE HEARD:

"A client must be served by any program to which they present"

Real Deal
No Wrong Door does not mean a client can obtain services from any possible program within the MHP

No Wrong Door refers to systems of care: MHP vs. MCP

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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
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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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CO-OCCURRING TREATMENT



WHAT YOU'VE HEARD:

"MH providers now have to treat substance use disorders and SUD providers now have to treat MH disorders"


REAL DEAL
Providers are not being required to work out of their scope. There is now greater flexibility; however, for assistance to be provided to a beneficiary while the provider works to connect the beneficiary to either MH or SUD services for more in depth support/treatment

BENEFITS
Greater flexibility for treatment providers
Beneficiaries are able to receive immediate support for their presenting concerns while being supported with connecting to the appropriate care



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CO-OCCURRING TREATMENT




WHAT YOU'VE HEARD:

"If we mention a SUD in our MH documentation, we are at risk to have the service disallowed" (and vice versa)

REAL DEAL
SMHS are covered whether or not the beneficiary has a co-occurring SUD that is mentioned in the clinical documentation or that is part of the beneficiary's treatment.
SUD services are covered by DMC and DMC-ODS whether or not the beneficiary has a co-occurring MH condition

BENEFITS
Services no longer disallowed due to mentioning SUD or MH in documentation
Greater flexibility for treatment providers
Beneficiaries receive more seamless treatment/services



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Documentation Reform

Policy Then	Policy as of July 1, 2022	Benefit
<p>Lengthy documentation requirements:</p> <ul style="list-style-type: none"> • Stringent requirements for clinical documents • “Treating chart instead of the individual” to avoid disallowances • Provider spending more time on documentation than on treating individuals 	<p>Lean documentation:</p> <ul style="list-style-type: none"> • Streamlined standards • Improved efficiency 	<ul style="list-style-type: none"> • 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
<p>Static treatment plans:</p> <ul style="list-style-type: none"> • Complex content requirements • Strict signature requirements • Firm due dates/renewal dates • Recoupments for services provided under an incomplete/expired treatment plan 	<p>Most treatment plan replaced by dynamic problem list:</p> <ul style="list-style-type: none"> • Treatment plan still required for the following: <ul style="list-style-type: none"> ✓ 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) 	<ul style="list-style-type: none"> • 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
<p>Disallowances for quality problems:</p> <ul style="list-style-type: none"> Excessive processes to avoid recoupments “Treating chart instead of the patient” to avoid disallowances Provider spending more time on documentation than treating 	<p>Disallowances focused on fraud, waste, abuse</p> <p>Corrective action plans for quality</p>	<ul style="list-style-type: none"> 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.)

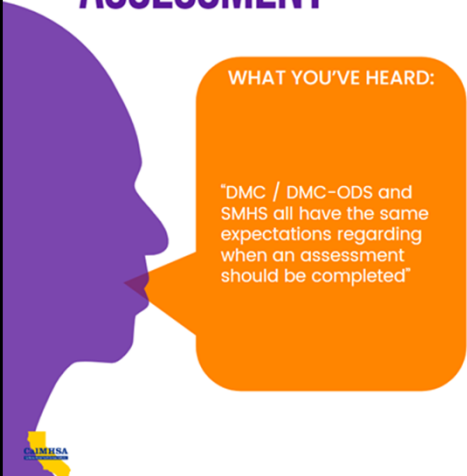
Behavioral Health Information Notice 22-019

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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ASSESSMENT



WHAT YOU'VE HEARD:

"DMC / DMC-ODS and SMHS all have the same expectations regarding when an assessment should be completed"

REAL DEAL

SMHS and DMC/DMC-ODS have slightly different rules. Covered and clinically appropriate DMC and DMC-ODS services (except residential) are Medi-Cal reimbursable for up to 30 days following the first visit with Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis is established or up to 60 days if the beneficiary is under 21 or if the provider documents that the beneficiary is experiencing homelessness and more time is needed for an assessment.

BENEFITS

Provides greater flexibility to the provider with regard to completing a thorough assessment

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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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PROBLEM LIST AND DIAGNOSIS



WHAT YOU'VE HEARD:

"The problem list replaces all treatment plans"

REAL DEAL

While mostly true, some services (TCM, ICC, IHBS, TFC, TBS, NTP, Peer Support Services) still require a treatment plan.

BENEFITS

Many services can be provided without a treatment plan

For TCM, the treatment plan requirements can be addressed within the narrative of a progress note instead of on a separate document



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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

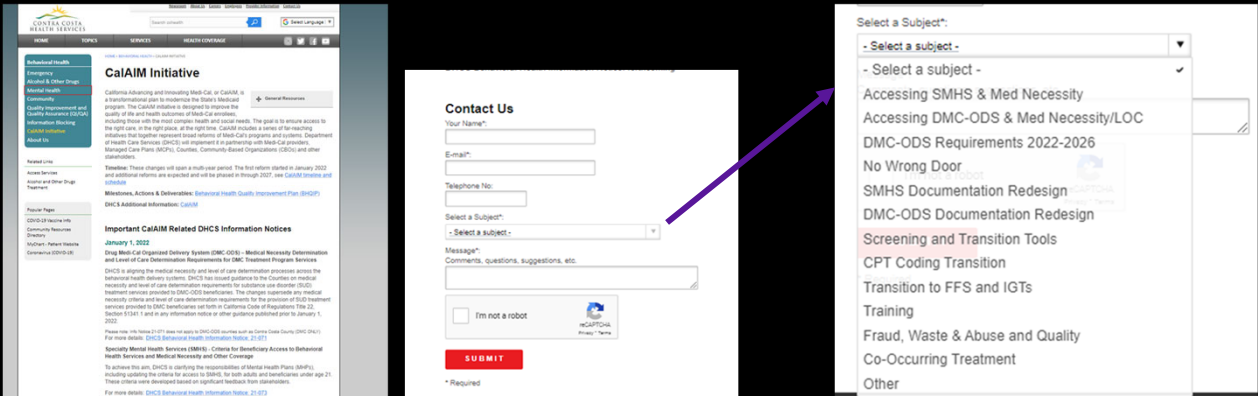
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Resources


CCBHS CalAIM Website: <https://cchealth.org/bhs/calaim> **Email:** CCBHSCalAIM@cchealth.org



The screenshot shows the website's 'Contact Us' form. A purple arrow points from the 'Select a Subject' dropdown menu to the email address. The dropdown menu is open, showing a list of subjects including 'Accessing SMHS & Med Necessity', 'DMC-ODS Requirements 2022-2026', 'No Wrong Door', 'SMHS Documentation Redesign', 'DMC-ODS Documentation Redesign', 'Screening and Transition Tools', 'CPT Coding Transition', 'Transition to FFS and IGTS', 'Training', 'Fraud, Waste & Abuse and Quality', 'Co-Occurring Treatment', and 'Other'.

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Resources (contd.)

CalMHSA Resources:
<https://www.calmhsa.org/calaim-support-for-counties/>

CalMHSA Documentation Guides: (available June 2022)
 role specific guides for both MH and SUD that encompass all clinical documentation standards. Will be updated in Jan 2023 to include CPT codes as part of payment reform.

Department of Health Care Services CalAIM:
<https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>



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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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Revisiting Goals of CalAIM Timeline

Goal 1: Payment Reform

Goal 2: Implementation of CalAIM Policy Changes

Goal 3: Data Exchange

Timeline

January 2022	July 2022	January 2023	July 2023	January 2027
Access Changes	Documentation Reform	Universal Screening Tools	Payment Reform	Mental Health Use and Substance Use Administrative Integration

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Q & A Session

FAQs to be posted on
CCBHS CalAIM Website



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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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