Please click the Survey Monkey link in the chat to take a quick three question survey

Welcome to CalAIM: Then vs. Now

California Mental Health Services Authority (CalMHSA)

April 27, 2022

Introductions

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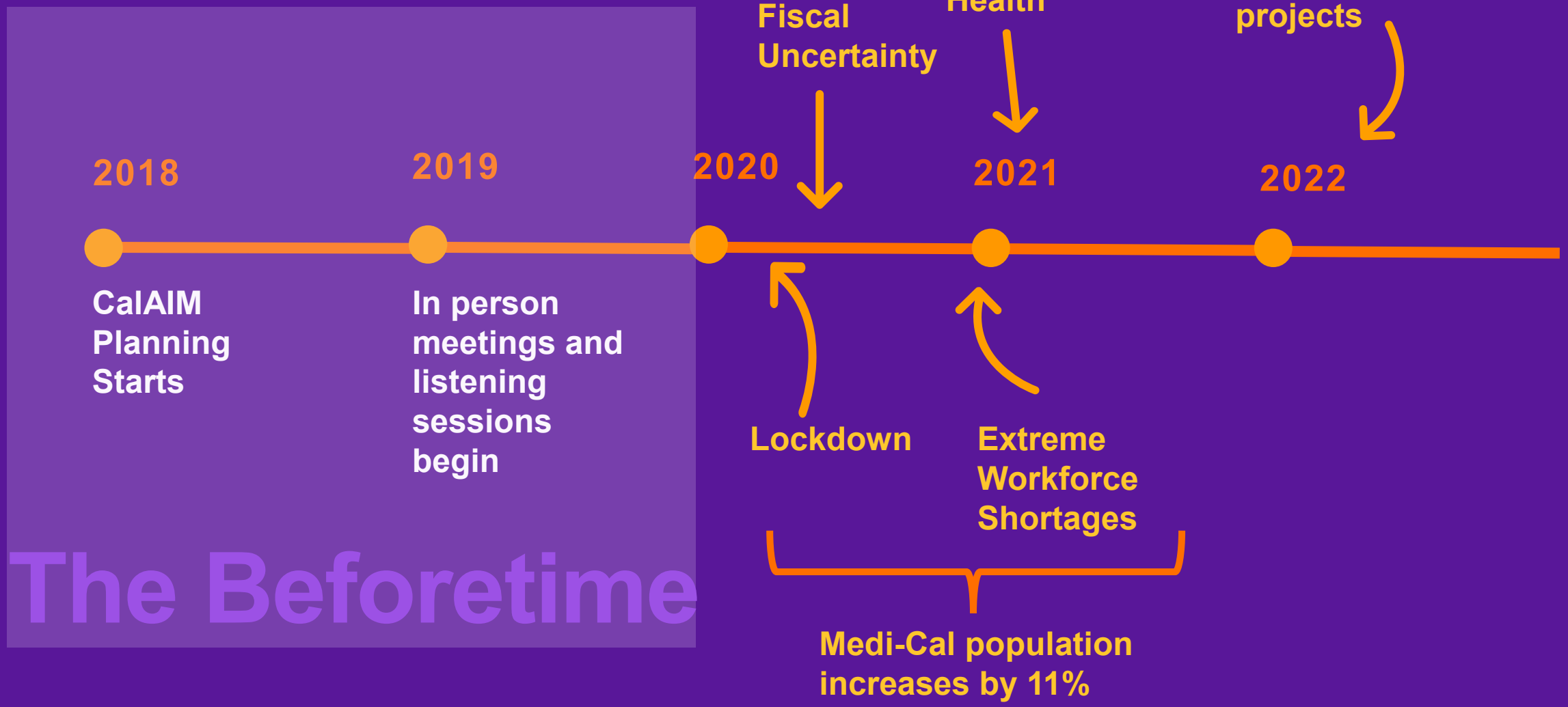
Training Objectives

PARTICIPANTS WILL WALK AWAY WITH:

- Clarity regarding the CalAIM training & supports being offered by CalMHSA
- An understanding of the main objectives of CalAIM
- Knowledge of what “used to be” and where we will be post-CalAIM as related to documentation reform
- An understanding of what constitutes fraud, waste and abuse

Grounding: When this started & where we have been

Timeline


Tons of interest in Behavioral Health
Many one-time funding projects
Fiscal Uncertainty
2018
2019
2020
2021
2022
CalAIM Planning Starts
In person meetings and listening sessions begin
Lockdown
Extreme Workforce Shortages
Medi-Cal population increases by 11%
The Beforetime

What has changed in the past two years?

NEARLY EVERYTHING

Real objectives

COUNTY BEHAVIORAL HEALTH SERVES THE MOST VUNERABLE PEOPLE IN THE STATE

THE MISSION IS CRITICAL AND THE JOB IS HARD

WITH HUMILITY, CALMHSA IS ATTEMPTING TO MAKE A GLIDE PATH TOWARDS IMPLEMENTATION

Timeline


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

CalMHSA Technical Assistance

TWO CATEGORIES:

1

Resources for Counties

2

Resources for Everyone

1 Resources for Counties

- Ten CalAIM Transformation Webinars for County Leadership & QI Staff
- Policies & Procedures
- Communication Plans (Includes Staff & Beneficiary Informing Materials)
- Monthly To-Do Lists
- Beyond 7/1/22: Payment Reform Support (CPT codes, IGT training, etc.)

Transformation Trainings

We are Here

Welcome to CalAIM: Then vs. Now	04/27/22
Shifting our Focus: Compliance vs. Quality	05/04/22
Communication Plans: Change Messaging	05/11/22
Initiating Treatment: No Wrong Door/Treatment Prior to Diagnosis	05/18/22
Standardizing Documentation: Universal Assessment	05/25/22
Identifying Treatment Focus: Problem List	06/01/22
Documenting Care: Progress Notes	06/08/22
No Money, No Mission: Billable vs. Non-Billable Services	06/15/22
Outcomes That Matter: Quality Measurement	06/22/22
You've Got This: CalAIM – A Summary	06/09/22

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Policies and Procedures

- Developing proposed policy and procedure templates & attestations for the following topics:
  - Access to SMHS; ASAM for DMCS, DMC-ODS Policy Improvements; Documentation Requirements; No Wrong Door; Screening & Transition Tools (later in 2022)
- Posted on CalMHSA's website

Communication Plans

- Includes Staff & Beneficiary Communication Materials
- Will provide concise information about CalAIM to be shared with staff and beneficiaries
- Posted on CalMHSA's website

Monthly To-Dos

- To-do lists that provide counties guidance on actions that need to occur each month as related to CalAIM

- Posted on CalMHSA's website

2 Resources for Everyone

- Documentation Guides
- Web-Based Documentation Training Videos
- Office Hours

Documentation Guides

- The aim is to create role-specific guides for both MH & SUD that encompass all clinical documentation standards
- Approved by DHCS
- To be published to CalMHSA's website in June
- All documentation guides will be updated January 2023 to include CPT codes as part of payment reform

Documentation Guides (cont.)

MH

1. LPHA
2. Medical Staff
3. Mental Health Rehab Specialist
4. Certified Peer Support Specialist

DMC & DMC-ODS

1. LPHA
2. Medical Staff
3. Alcohol and Drug Counselors
4. Certified Peer Support Specialist

Web-Based Documentation Training Videos

CalMHSA is developing a series of web-based documentation training videos on the following topics:

- CalAIM Overview
- Assessment
- Access to SMHS/DHCS/DMC-ODS
- Diagnosis/Problem List
- Care Coordination
- Progress Notes
- Discharge Planning
- Screening & Transition Tools (in late 2022)

Web-Based Documentation Training Videos (cont.)

- All trainings will be loaded into our CalMHSA learning management system (LMS)
- Users can log on and take trainings with pre and post tests
- Counties can then pull a list of everyone who has taken trainings for BHQIP reporting
- CalMHSA can provide copies of the trainings for your own LMS system

Office Hours

- Weekly opportunities for those who have received training to pose questions regarding CalAIM
- Every Wednesday in June from 2pm-3pm & Every Wednesday in July, August and September from 1pm-2pm
- Links to office hours are on CalMHSA's website

Moving On!

We Must Break Away From “What Used To Be” and Embrace the New CalAIM World

CalAIM Overview

CalAIM has three primary goals:

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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Let’s discuss the importance of documentation standardization

Fraud Waste and Abuse: What is it really?

Introducing our friendly local fraud, waste, and abuse attorney:
Kenneth Julian

“Fraud, Waste & 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.

“Fraud, Waste & 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).

More About “Fraud, Waste & Abuse” (cont.)

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.

More About “Fraud, Waste & Abuse” (cont.)

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.

Examples of Fraud, Waste & Abuse

Fraud	Waste	Abuse
Deliberately claiming for services that were not provided	Large scale duplicative services	Billing for a non-covered service
Prescribing/ordering/providing unnecessary medications, treatments, labs, etc.	Providing services/procedures/medications that are not medically necessary	Inappropriately allocating costs on a cost report
Claiming reimbursement for treating an individual other than the eligible individual		
Intentionally billing for an ineligible individual		

What is NOT Fraud, Waste or 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

What is NOT Fraud, Waste or Abuse? (cont.)

- 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

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.

What Conduct Can Raise An Inference of Fraud, Waste or Abuse? (cont.)

- Intentional concealment of known errors or overpayments.

  Example: use of inaccurate statements, or deliberate failure to disclose adverse facts, in response to audit questions.

Final Thoughts on Fraud, Waste & Abuse

- 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).

Let's Compare Policies "Then" vs. "Now" & The Impacts on People (i.e., the Benefit)

Criteria for Access to SMHS (Medical Necessity)

Policy Then	Policy Now	Benefit
Unclear, outdated and restrictive medical necessity criteria: • Creates challenges for individuals attempting to access care • A burden to providers/creates risk of disallowance	Updated and clarified medical necessity criteria for SMHS for both adults and children Bringing definition of “Medical Necessity” into alignment with Welfare and Institutions Code 14184.402(a) for those 21 and over and with Section 1396(r)(5) of Title 42 of the US Code for individuals under 21	• Easier for individuals to access needed treatment (for those under 21,criteria takes trauma into account: trauma screening, CWS involvement, justice involvement, homelessness) • Less burden on providers • Decreased risk of disallowance during audits

No Wrong Door

Policy Then	Policy Now	Benefit
Individuals navigate a confusing system to find the correct care: • Some individuals never get the treatment they need due to being "bounced" between the MHP and MCP • Providers feeling rushed to determine if the individual is or is not a "fit" for services	A "no wrong door" policy ensures individuals receive treatment regardless of the delivery system where they seek care: • Allows individuals who directly access a treatment provider to receive an assessment and mental health services • Ensures provider reimbursement even if the individual is ultimately transferred	• Individuals will no longer be turned away due to the MHP or MCP being concerned about the appropriate level of care • Increased flexibility for providers • Supports individuals with continuing therapeutic relationships when appropriate

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Treatment Prior to Establishing Diagnosis

Policy Then	Policy Now	Benefit
• Services not reimbursable prior to diagnosis • Providers not reimbursed for extensive time spent conducting assessments • Confusing rules about what services can be provided prior to diagnosis	Services are reimbursable prior an official diagnosis • Flexibility regarding timeline for diagnosis • Not rushed into diagnosing before getting to know an individual and their needs. • Can utilize Z codes when appropriate	• Providers can be reimbursed for services provided • Supports more accurate diagnosing • Less provider confusion regarding what is and is not billable prior to a diagnosis determination

Co-Occurring Treatment

Policy Then	Policy Now	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

Documentation Reform

Policy Then	Policy Now	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

Documentation Reform (continued)

Policy Then	Policy Now	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
	No treatment plan (replaced by dynamic problem list):
	
	• "Treatment plan" required via a progress note
	  • Targeted Case Management
	  • Peer Support Services
	  • Intensive Care Coordination (ICC)
		• Less time spent on unnecessary documents
		
		• Simplified internal auditing processes
		
		• Decrease in unnecessary recoupments

Documentation Reform (continued)

Policy Then	Policy Now	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

Feedback? Questions?

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Thank You!

Please click the NEW Survey Monkey link in the chat to complete our post-training evaluation

THANK YOU!