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

2018
CalAIM Planning Starts

2019
In person meetings and listening sessions begin

2020
Fiscal Uncertainty
Lockdown

2021
Tons of interest in Behavioral Health
Extreme Workforce Shortages

2022
Many one-time funding projects

The Beforetime

Medi-Cal population increases by 11%
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
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.)
<table>
<thead>
<tr>
<th>Transformation Trainings</th>
<th>Date</th>
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<tbody>
<tr>
<td>Welcome to CalAIM: Then vs. Now</td>
<td>04/27/22</td>
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<tr>
<td>Shifting our Focus: Compliance vs. Quality</td>
<td>05/04/22</td>
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<tr>
<td>Communication Plans: Change Messaging</td>
<td>05/11/22</td>
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<tr>
<td>Initiating Treatment: No Wrong Door/Treatment Prior to Diagnosis</td>
<td>05/18/22</td>
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<tr>
<td>Standardizing Documentation: Universal Assessment</td>
<td>05/25/22</td>
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<tr>
<td>Identifying Treatment Focus: Problem List</td>
<td>06/01/22</td>
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<tr>
<td>Documenting Care: Progress Notes</td>
<td>06/08/22</td>
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<tr>
<td>No Money, No Mission: Billable vs. Non-Billable Services</td>
<td>06/15/22</td>
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<tr>
<td>Outcomes That Matter: Quality Measurement</td>
<td>06/22/22</td>
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<tr>
<td>You’ve Got This: CalAIM – A Summary</td>
<td>06/09/22</td>
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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
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
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.
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

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

Let’s Compare Policies “Then” vs. “Now” & The Impacts on People (i.e., the Benefit)
# Criteria for Access to SMHS (Medical Necessity)

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclear, outdated and restrictive medical necessity criteria:</td>
<td>Updated and clarified medical necessity criteria for SMHS for both adults and children</td>
<td>• Easier for individuals to access needed treatment (for those under 21, criteria takes trauma into account: trauma screening, CWS involvement, justice involvement, homelessness)</td>
</tr>
<tr>
<td>• Creates challenges for individuals attempting to access care</td>
<td>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</td>
<td>• Less burden on providers</td>
</tr>
<tr>
<td>• A burden to providers/creates risk of disallowance</td>
<td></td>
<td>• Decreased risk of disallowance during audits</td>
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</table>
# No Wrong Door

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

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

<table>
<thead>
<tr>
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<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services would be disallowed if a co-occurring condition was as part of the individual’s treatment</td>
<td>• Co-Occurring Treatment allows for treatment to begin “through any door” regardless of co-occurring diagnoses that may be present</td>
<td>• Individuals experience streamlined process for obtaining services</td>
</tr>
<tr>
<td>• Confusing experience for individuals seeking services</td>
<td>• Treatment in the presence of a co-occurring disorder is reimbursable</td>
<td>• Providers can take time to assess the needs of the individual</td>
</tr>
<tr>
<td>• Fiscal implications</td>
<td></td>
<td>• Fewer services disallowed</td>
</tr>
</tbody>
</table>
# Documentation Reform

<table>
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<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lengthy documentation requirements:</td>
<td>Lean documentation:</td>
<td>• Less time documenting</td>
</tr>
<tr>
<td>• Stringent requirements for clinical documents</td>
<td>• Streamlined standards</td>
<td>• More time to focus on direct services</td>
</tr>
<tr>
<td>• “Treating chart instead of the individual” to avoid disallowances</td>
<td>• Improved efficiency</td>
<td>• Decreased provider burnout</td>
</tr>
<tr>
<td>• Provider spending more time on documentation than on treating individuals</td>
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</table>
## Documentation Reform (continued)

<table>
<thead>
<tr>
<th>Policy Then</th>
<th>Policy Now</th>
<th>Benefit</th>
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</thead>
<tbody>
<tr>
<td><strong>Static treatment plans:</strong></td>
<td><strong>No treatment plan (replaced by dynamic problem list):</strong></td>
<td><strong>• Less time spent on unnecessary documents</strong></td>
</tr>
<tr>
<td>• Complex content requirements</td>
<td>• “Treatment plan” required via a progress note</td>
<td><strong>• Simplified internal auditing processes</strong></td>
</tr>
<tr>
<td>• Strict signature requirements</td>
<td>• Targeted Case Management</td>
<td><strong>• Decrease in unnecessary recoupments</strong></td>
</tr>
<tr>
<td>• Firm due dates/renewal dates</td>
<td>• Peer Support Services</td>
<td></td>
</tr>
<tr>
<td>• Recoupments for services provided under an incomplete/expired treatment plan</td>
<td>• Intensive Care Coordination (ICC)</td>
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</table>
## Documentation Reform (continued)

<table>
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<tr>
<th>Policy Then</th>
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<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disallowances for quality problems:</td>
<td>Disallowances focused on fraud, waste, abuse</td>
<td>• Decrease in unnecessary recoupments</td>
</tr>
<tr>
<td>• Excessive processes to avoid recoupments</td>
<td>Corrective action plans for quality</td>
<td>• Decreased provider burnout</td>
</tr>
<tr>
<td>• “Treating chart instead of the patient” to avoid disallowances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider spending more time on documentation than treating</td>
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Feedback? Questions?

Calaim@calmhsa.org
Thank You!
Please click the NEW Survey Monkey link in the chat to complete our post-training evaluation
THANK YOU!