CalAIM 2022

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CalAIM vision: what does it mean for counties?

- Identify and manage comprehensive needs through whole person care approaches and social drivers of health
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

» Increasing state and federal pressure to perform as managed care plans:
  » Increasing expectations re managed care processes (such as managing grievances, interoperability standards)
  » Increasing expectations re quality improvement (measurement targets, expected improvements over baseline, quality improvement projects)
  » Increasing use of administrative actions and sanctions (such as not meeting network adequacy standards related to provider ratios, required providers and/or facilities, time and distance standards, timely access, or contract requirements)
  » Entitlements to robust, timely, high-quality continuum of care

» Alignment with Medi-Cal managed care (medical and dental):
  » Monitoring, oversight, reporting expectations related to compliance, quality, equity, contract performance
  » Payment methodologies, starting with fee-for-service and building towards capitation
  » Combined external quality review organization
CalAIM changes expectations for Counties

Streamline, simplify and modernize the delivery of health care in Medi-Cal

Behavioral health policy reforms

• **Simplify who can get care**: streamlining specialty mental health criteria (“medical necessity”), allowing care prior to diagnosis, care of people with co-occurring mental health and substance use disorder, “no wrong door”

• **Improve experience and workforce retention**: simplifying documentation standards

• **Standardize entry points into care** across mental health and managed care plans: new screening tool

• **Standardize transitions** across mental health plans and managed care: new transition tool

• **Improve coordination and communication** between counties and Medi-Cal managed care plans

• **Update the Drug Medi-Cal Organized Delivery System**: from pilot to standard of care

• **Shift recoupment practices**: focus on fraud/waste and abuse: reduce audit risk
CalAIM changes expectations for Counties

CalAIM is designed to streamline, simplify and modernize the delivery of health care in Medi-Cal

- **Behavioral health payment reform**
  - Invest in county financial sustainability through fee for service instead of cost-based reimbursement: lower administrative burden and fiscal risk
- **Behavioral Health Quality Improvement Program** – up-front investments to support infrastructure building:
  - Preparing for payment reform
  - Implementing policy reforms
  - Supporting data exchange
- **Population health:**
  - Right care, right time, to those who need it
  - Priority populations:
    - Children and youth, especially those in foster care
    - Homelessness
    - Justice-involved
CalAIM Justice Initiative

90-day in-reach still under negotiation with CMS. Goal: give DHCS and corrections facilities enough time to enroll individuals in Medi-Cal, screen for access criteria for the pre-release services, assign a care manager, meaningfully engage with the individual, and set up 30-day prescriptions and medical equipment for release.

<table>
<thead>
<tr>
<th>Building Trusted Relationships</th>
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<td>The 90-day period allows a care manager to visit multiple times with the individual while they are incarcerated. This ensures enough time to:</td>
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<td>» Develop a transition plan</td>
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<td>» Coordinate care</td>
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<td>» Support stabilization upon re-entry</td>
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<td>» Build familiarity and trust in a way that ensures continuity once an individual reenters the community</td>
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<th>Pre-Release Management and Stabilization</th>
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<td>The 90-day period allows for:</td>
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<td>» Better management of medical conditions, and reduce visits to emergency departments and hospitals after release</td>
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<tr>
<td>» Stabilization of mental health and SUD treatment, including injectable long-acting anti-psychotics and medications for addiction treatment: reduce decompensation and overdoses after release</td>
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<th>Connecting to Services Post-Release</th>
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<td>» Sufficient time to coordinate seamless hand-offs to community-based physical and behavioral health treatment, and supportive social services upon re-entry.</td>
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<td>» Adequate time for data sharing with managed care plans and counties to enable seamless hand-offs</td>
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<tr>
<td>» Adequate time for the coordination and provision of durable medical equipment (oxygen, wheelchairs, wound care supplies) for post-release</td>
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What is “Providing Access and Transforming Health” (PATH)?

California has received expenditure authority as part of its section 1115 demonstration renewal for the “Providing Access and Transforming Health” (PATH) program to take the State’s system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. DHCS received partial authorization for $1.85 billion total computable funding to support for PATH to maintain, build, and scale the capacity necessary to ensure successful implementation of key features of CalAIM.*

*DHCS is still actively negotiating approval for $410 million in expenditure authority to support the PATH Justice-Involved Capacity Building Program
## PATH Programs and Initiatives

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<th>PATH Initiative Name</th>
<th>High-Level Description</th>
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<tr>
<td><strong>WPC Services and Transition to Managed Care Mitigation Initiative</strong></td>
<td>Time limited support to sustain existing WPC pilot services that have converted to Community Supports and that MCPs have committed to cover, through the transition (no later than January 2024).</td>
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<td><strong>Technical Assistance Initiative</strong></td>
<td>Technical assistance to providers, community-based organizations, county agencies, public hospitals, tribes, and others through a virtual marketplace.</td>
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<td><strong>Collaborative Planning and Implementation Initiative</strong></td>
<td>Support for regional/county-based collaborative planning and implementation efforts among MCPs, providers, community-based organizations, county agencies, public hospitals, tribes, and others to promote readiness for ECM and Community Supports.</td>
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<tr>
<td><strong>Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative</strong></td>
<td>Enabling the transition, expansion, and development of capacity and infrastructure for providers, community-based organizations, county agencies, public hospitals, tribes, and others to provide ECM and Community Supports.</td>
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<tr>
<td><strong>Justice Involved Planning and Capacity Building Initiative</strong></td>
<td>Funding to support implementation of pre-release Medi-Cal enrollment and suspension processes in jails, youth correctional facilities, and state prisons.</td>
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Behavioral Health Payment Reform
Payment Reform Goals & Timing

» Today, reimbursements to counties are limited to costs incurred by the counties and subject to a lengthy and labor-intensive cost reconciliation process.

» CalAIM seeks to move counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal beneficiaries.

Go Live: July 1, 2023
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<th>Key Elements</th>
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<td>1. Transition counties from cost-based reimbursement to fee-for-service.</td>
<td>Transition from Certified Public Expenditures to Intergovernmental Transfers for the county provided non-federal share.</td>
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Transition to Fee-for-Service

» Counties will be paid a fixed rate for a particular service, no cost settlement.
  » Rate development will be informed by the best available cost data, however, payments will not be reconciled to actual costs incurred as they are today.

» The rate schedule established by DHCS is for reimbursement to counties.
  » Provider payment rates will be negotiated between counties and their contracted providers.
Transition to IGTs

» IGTs will be the new mechanism for supplying non-federal share, replacing CPEs.
  » Unlike CPEs, IGTs do not require an expenditure to have already occurred to draw down federal matching funds.

» While the mechanism is changing, counties will continue to use the same sources of non-federal share, such as 1991 Realignment and MHSA.
Payment Reform Guidance

» Updated Billing Manuals (effective July 1, 2023) and other coding transition guidance.
  » SMH Billing Manual
  » 837 Companion Guides
  » Coming soon:
    » DMC Billing Manual
    » DMC-ODS Billing Manual
    » HCPCS to CPT Coding Crosswalk

» Additional guidance is forthcoming.
  » County rate schedule, pending CMS engagement through summer 2022.
  » CPE to IGT transition Information Notice.

DHCS inbox for questions: bhpaymentreform@dhcs.ca.gov