CalAIM Justice-Involved Initiative: Care Management Bundles

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Background

California received approval to authorize federal Medicaid matching funds for select Medicaid services, including care management services, for eligible incarcerated individuals in the 90-day period prior to release from incarceration in state and county correctional facilities (CFs).

The pre-release services authorized under the JI Initiative include the following services currently covered under DHCS's Medicaid and CHIP State Plans. DHCS will pay for all pre-release services under Medi-Cal FFS.

★ ***Reentry care management services;*** → ***Focus of presentation***

- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medication for substance use disorder (SUD) (also known as MAT), for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Services provided by community health workers with lived experience.

In addition to the pre-release services specified above, qualifying individuals will also receive covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and durable medical equipment (DME) upon release, consistent with approved state plan coverage authority and policy.

Care Management Bundles

DHCS developed five care management bundles to support Medicaid billing and claiming. These care management bundles include services that are provided and/or overseen by a pre-release care manager / post-release care manager.

- Care Management bundles should only be delivered and billed as clinically necessary.
- Bundles 1, 2, and 4 will be billed by the pre-release care manager; if a warm handoff is required, Bundle 3 will be billed by both the pre-release and post-release care manager.
- *Note: The care management bundles do not include Community Health Worker (CHW) services, such as patient outreach and education. Supervisors of in-reach CHW will be able to bill Medi-Cal directly for the delivery of CHW services.*

Descriptions and billing details for the five care management bundles can be found in the Appendix of this slide deck.

Care Management Bundles

Bundle 1: Health Risk Assessment

Bundle 2: Care Coordination

Bundle 3: Care Manager Warm Handoff

Bundle 4: Reentry Care Plan

Bundle 5: Post-Transition Support

Care Management Providers

DHCS will allow both in-reach community-based providers (including community-based care managers/ECM providers) and providers embedded in the CF (including CF staff and contractors) to provide pre-release care management. All pre-release providers must bill for pre-release care management under an enrolled Medi-Cal fee-for-service (FFS) provider.

CFs may adopt an in-reach care management model, an embedded care management model, or a mixed care management model where they will assign both in-reach and embedded pre-release care managers

In-Reach Care Managers:

- Community-based care management providers who will deliver pre-release care management services to individuals in CFs (in person or via telehealth).
- This community-based provider should become the ECM provider after an individual's release and enrollment into managed care.

Embedded Care Managers:

- Care managers directly employed or contracted with CFs to deliver pre-release care management services to individuals in CFs (in person or via telehealth).
- *Note: If an embedded care management model is used, CFs will be required to implement a warm handoff between the pre-release care manager and post-release ECM provider (in person or via telehealth).*

More information on existing Medi-Cal provider types for community-based providers can be found in Section 9.2 of the Policy and Operational Guide.

Billing Codes and Rates for Care Management

DHCS will reimburse for all pre-release services under Medi-Cal FFS. Claims for care management services will be submitted by qualifying providers through normal processes utilizing CA-MMIS.

Bundle	Billing Code	Bundle Description	Base Bundle Rate	*Base Bundle Rate Plus In-Reach	Max Billing Frequency
1	G9001	Health Risk Assessment	$256.27	$281.90	1
2	G9002	Care Coordination	$52.16	$57.38	13
3	G9012	Care Manager Warm Hand-Off	$166.70	$183.37	1 for each care manager (max 2)
4	T2024	Reentry Care Plan	$199.00	$218.90	1
5	TBD	Post-Transition Support	TBD	N/A	11 (2 pre-release care manager, 9 post release care manager)

**In-reach, in-person visits will receive a 10% in-reach administrative rate increase. Bundle 5 is inapplicable for in-reach increase. See detailed requirements for each bundle and administrative rate increase in Appendix and forthcoming updated Policy Guide.*

Reimbursement Policy

Objectives of Reimbursement Policy:

- Minimize administrative burden on correctional facilities and streamline billing for flat bundles of care management activities.
- Incentivize in-reach and community care to support relationship building upon re-entry into the community.
- Maintain fairness and parity in services.
- Develop rates that are sustainable for California practitioners.

Rate Development Methodology

- For each bundle, DHCS developed time assumptions for licensed and unlicensed providers to provide each bundle. These assumptions were developed by clinical consultants and incorporated feedback from stakeholders.
- DHCS developed practitioner hourly cost assumptions based on California annual mean wages reported in the U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics.
    - For licensed providers, DHCS assumed a blend of 75% Healthcare Social Worker and 25% Registered Nurse occupations.
    - For unlicensed providers, DHCS assumed 100% Community Health Worker occupation.
- Salary costs were adjusted for inflation, benefits, and an overhead component to develop a "fully loaded" practitioner hourly cost.
- For each bundle, DHCS calculated the rate as a sum of the practitioner hourly cost multiplied by the time required for each practitioner type.
- Services provided through in-reach, in-person visits receive an additional 10% increase to account for the additional complexities and time for non-facility providers to deliver services in correctional facilities.

Billing for Care Management Services

Medi-Cal Fee for Service (FFS)

Pre-Release Care Management Services

Care management services will be billed FFS and claimed through normal processes utilizing the California Medicaid Management Information System (CA-MMIS).

Post-Release Care Management Services

Post-release care management services will be billable via FFS ***until*** the MCP enrollment has been effectuated.

Managed Care Plan

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is delivered and paid for in the managed care delivery system via the **Medi-Cal Managed Care Plan (MCP)** in which the individual is enrolled post-release.

More information on care management bundles can be found in Section 10.2 of the Policy and Operational Guide.

Available Resources

- Policy and Operational Guide:
  - Section 8.4 Care Management Model
  - Section 10.2 Proposed Approach for Care Management Bundles
- CalAIM Justice-Involved Inbox: *CalAIMJusticeAdvisoryGroup@dhcs.ca.gov*.
- Additional resources are forthcoming.

Questions

Appendix

Bundle 1: Health Risk Assessment / Whole-Person Needs Assessment

Overview

- Pre-release care managers are responsible for ensuring the completion of a **health risk assessment (HRA)** and documentation of pre-release services goals and objectives. The HRA should be used to identify goals and objectives, including additional clinical care or clinical assessments that are needed to diagnose, stabilize, or treat in preparation for reentry.
- Both the HRA and the goals and objectives must be documented in the medical record and must include assessment of needs and pre-release goals and objectives in each of the following areas:
  - Physical health;
  - Mental health;
  - Substance use;
  - Housing; and
  - Other health-related social needs, functional needs, and strengths and support resources.
- Required components of the HRA are listed in **Table 15 of Section 10.2.a. of the Policy and Operational Guide.**

Minimum Documentation

- **Completed whole-person HRA*:*** Must include assessment of all required components of the HRA. Must include documentation of at least one face-to-face or telehealth encounter with member directly by a licensed professional.
- **Completed pre-release services goals and objectives for the member*:*** Must include documentation of at least one face-to-face or telehealth encounter with member directly by a licensed professional.

Billing Frequency

Once per member, per episode of incarceration.

- May be billed by either an in-reach pre-release care manager or an embedded pre-release care manager, but not both.

If the pre-release care manager does not meet the minimum requirements to bill this bundle, they may bill Bundle 2 for partial completion up to 3 times. See Bundle 2 for details.

Bundle 2: Care Coordination

Overview

- **Pre-release care managers** are responsible for creating care links and coordinating with community-based providers and services. Responsibilities of the pre-release care manager include:
  - Coordinating with post-release clinical consultants;
  - Establishing of links to community-based providers;
  - Arranging appointments with physical and behavioral health providers;
  - Ensuring member has any necessary DME prescriptions;
  - Assisting in information exchange and obtaining consent, as needed;
  - Assisting with submission of prior authorization or treatment authorization requests;
  - Facilitating a warm handoff with member and community-based provider; and
  - Ensuring coordination and receipt of pre-release services.
- In some cases, **the post-release ECM providers may also provide similar services in the pre-release setting.**
  - **Ex**: There may be scenarios in which the pre-release care manager is an embedded provider and needs assistance with connections to community services of which the post-release ECM provider may have significantly more knowledge than the embedded care manager.

Minimum Documentation

- Minimum documentation needed to bill for this bundle can be found in **Section 10.2.b. of the Policy and Operational Guide.**

Billing Frequency

- Maximum of **13x per member,** per episode of incarceration, across all providers. No more than **8x total per week**, per member, per episode of incarceration, across all providers.
- **Pre-release care managers (in-reach or embedded) or post-release ECM providers may bill this bundle** and must coordinate to ensure the bundle does not get billed more than 13 times total per member, per episode of incarceration.
- **Post-release ECM providers may bill this bundle only in cases where the pre-release care manager is an embedded provider and needs assistance with connections to community services of which the post-release ECM provider may have significantly more knowledge than the embedded care manager.** In this scenario, both the post-release ECM provider and the pre-release care manager may bill this bundle if they each separately meet minimum documentation requirements.

Bundle 3: Care Manager Warm Handoff

Overview

- In scenarios where the pre-release care manager is different from the post-release care manager, the pre-release care manager must arrange and participate in an **in-person or telehealth warm handoff.** The warm handoff will serve as an opportunity to introduce the new post-release ECM provider, review the reentry care plan (including the health risk assessment and goals and objectives), and identify any additional needs. Requirements to bill for the warm handoff can be found in **Section 10.2.c. of the Policy and Operational Guide.**
- In scenarios where it is not possible to arrange a meeting between the pre-release care manager, post-release care manager, and member:
  - The pre-release care manager and post-release ECM provider should make every effort to conduct a warm handoff meeting with each other, even if the member is unable to attend; and
  - The post-release care manager should make every effort to meet with the member to introduce themselves and prepare for reentry.

Minimum Documentation

For Post-Release ECM Provider:

- Documentation of participating in a face-to-face or telehealth encounter with the member to introduce themselves and review the HRA and/or reentry care plan to identify any additional needs.
- If the post-release ECM provider meets with the pre-release care manager without participation from the member, the post-release ECM provider may bill Bundle 2.

For Pre-Release Care Manager:

- Documentation of participating in a face-to-face or telehealth encounter **that must include the member and the post-release provider.**

Billing Frequency

Once per member, per episode of incarceration.

- May be billed by both the pre-release and post-release care manager if different.

This bundle will only be billable if the pre-release care manager is different from the post-release ECM Provider (for example, in an embedded pre-release care manager model).

Bundle 4: Reentry Care Plan

Overview

- The pre-release care manager is responsible for completing a **final reentry care plan** documented in the medical record including release plans related to physical health, mental health, substance use, housing needs, other health-related social needs, functional needs, and strengths and support resources.
- The final reentry care plan **must be completed in collaboration with the member** and must be shared with the post-release ECM provider, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent).
- Some requirements for the warm handoff include:
  - Complete reentry care plan created with the member;
  - Complete data exchange;
  - Confirmation that individual has medications/prescriptions in hand upon release;
  - Confirmation individual has necessary DME upon release;
  - Confirmation individual has Benefits Identification Card (BIC) upon release.

Minimum Documentation

- A completed final reentry care plan
- Documentation that the reentry care plan was shared with the post-release ECM provider, MCP, county behavioral health agency (if applicable), the member, and the member's family/support persons (in accordance with the member's consent).
- Documentation to confirm that (1) medications/medication prescriptions and (2) DME/DME prescriptions are provided in hand at time of release, as applicable, to the member, with relevant education. Medication lists and a copy of DME prescriptions must also be given to either the ECM provider or MCP.

Billing Frequency

Once per member, per episode of incarceration.

- May be billed by either an in-reach pre-release care manager or an embedded pre-release care manager, but not both.

If the pre-release care manager does not meet the minimum requirements to bill this bundle, they may bill Bundle 2 for partial completion up to 3 times. See Bundle 2 for details.

Bundle 5: Post-Transition Support

Overview

- Some members may require **additional post-transition support in the period immediately following reentry to the community.** For example, there may be scenarios in which the care manager warm handoff was unable to be completed prior to release, **requiring the pre-release care manager and the post-release ECM provider to work together** to ensure adequate support in the critical days following reentry; or there may be situations where the individual is not yet enrolled in an MCP and requires additional time in the FFS environment.
- Activities that the **post-release ECM provider** may perform (if MCP enrollment has not yet been activated) include:
  - Participating in a warm handoff meeting with the pre-release care manager if this was not done prior to release;
  - Conducting a face-to-face or telehealth visit with the member;
  - Conducting follow-up activities with community-based providers; and
  - Other care coordination activities (e.g., supporting scheduling of appointments, completing applications for services).
- Activities that the **pre-release care manager** may perform (if MCP enrollment has not yet been activated) include:
  - Activities related to the warm handoff with post-release ECM provider.

Minimum Documentation

- The **post-release ECM provider** may only bill this bundle prior to the MCP enrollment effective date. Once the individual's MCP enrollment is active, services must be authorized and reimbursed by the MCP in accordance with the MCP's policies.
- The **pre-release care manager** may only bill this bundle if the care manager warm handoff did not occur prior to release due to rapid or unexpected circumstances or circumstances outside of the correctional facility's control that prevented warm handoff prior to release.
- Minimum documentation needed to bill for this bundle can be found in **Section 10.2.e. of the Policy and Operational Guide.**

Billing Frequency

For Post-Release ECM Provider:

- Maximum of 5x per week, with maximum of 9x total over 28 calendar days (4 weeks) (per member, per episode of incarceration).
- **May not be billed after 28 calendar days post-release.**

For Pre-Release Care Manager:

- Up to 2x within 1-week post-release (per member, per episode of incarceration).
- **Only billable if the care manager warm handoff did not occur prior to release.**

In-Reach, In-Person Modifier

Overview

- DHCS will provide tiered rates for in-reach, in-person visits for the following professional services:
  - Care Management
  - Clinical Consultations
  - Community Health Worker Services
- The **QJ modifier** will be utilized for in-reach, in-person visits.
- In-reach, in-person reimbursement will be an augmented rate that is 10% higher than the base rate for these services.
- This increased rate will account for the unique additional complexities and time for individual providers to pass through security clearance and deal with appointment cancellations due to lockdowns or other unique CF challenges.

Requirements

- The QJ Modifier must be included on the billing claim.
- The place of service must be the correctional facility.

Special Notes

- Use of the QJ modifier is optional.
- Claims submitted without the QJ modifier will be paid at the base rate, assuming all other billing requirements are met.
- Documentation to verify in-reach, in-person visits is not required.

Rate Methodology: Provider Time Assumptions

Bundle	Bundle Description	Licensed Provider Time (Minutes)	Unlicensed Provider Time (Minutes)
1	Health Risk Assessment	90	120
2	Care Coordination	15	30
3	Care Manager Warm Handoff	105	0
4	Reentry Care Plan	45	135
5	Post-Transition Support	15	30