Criteria for Beneficiary Access to Specialty Mental Health Services Outpatient Services

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Purpose and Goal of Cal-AIM

California Advancing and Innovating Medi-Cal (CalAIM) is a Department of Health Care Services (DHCS) initiative that aims to

- Provide broad delivery system, program and payment reform across the Medi-Cal system.
- The goal of the initiative is to transform the Medi-Cal delivery system, moving it towards a population health approach that prioritizes prevention and whole person care.

Cal-AIM Timeline

Policy	Go-Live Date
Criteria for Specialty Mental Health Services	January 2022
Drug Medi-Cal Organized Delivery System 2022-2026	January 2022
Drug Medi-Cal ASAM Level of Care Determination	January 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2021-2022	January 2022
Documentation Redesign for Substance Use Disorder & Specialty Mental Health Services	July 2022
Co-Occurring Treatment	July 2022
No Wrong Door	July 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023	October 2022
Standardized Screening & Transition Tools	January 2023
Behavioral Health CPT Coding Transition	July 2023
County Behavioral Health Plans Transition to Fee-for-Service and Intergovernmental Transfers	July 2023
Administrative Behavioral Health Integration	January 2027

DHCS Medical Necessity Information Notice

- On December 10, 2021, the Department of Health Care Services (DHCS) released BHIN 21-073, providing additional details related to the updated access criteria, **effective January 1, 2022.**

- The guidance **does not** require agencies to make any changes to client records dating back to January.

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Diagnosis Change Highlights

- Seeking a **"No Wrong Door"** that addresses beneficiary needs across the continuum of care, an "Included" DSM/ICD-10 diagnosis is no longer required for SMHS access.
- Eligibility criteria for beneficiaries under 21 years of age now includes **"high risk for a mental health disorder due to the experience of trauma"**, as evidenced by a high score on a state-approved trauma screening tool, child welfare or juvenile justice involvement, and/or homelessness
- A mental health **diagnosis is not a prerequisite** for access to covered SMHS. This **does not eliminate** the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.

What does this all mean?

Coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service **is not excluded under any of the following circumstances**:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
- The beneficiary has a co-occurring substance use disorder.

These claims will no longer result in disallowances.

Managed Care Plan Responsibilities

Services for symptoms or conditions **solely due to a medical condition** (e.g. traumatic brain injury) remain the responsibility of the Managed Care Plan (MCP) or the Fee-for-Service (FFS) delivery system.

MCPs will **continue to serve** beneficiaries 21 years of age and over with **mild to moderate** mental disorders, beneficiaries under 21 eligible for services through the EPSDT benefit regardless of the level of distress or impairment or the presence of a diagnosis, and beneficiaries of any age with potential mental health disorders not yet diagnosed.

Criteria Effective January 1, 2022

- **For beneficiaries 21 years of age or older**, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

  The beneficiary has one or both of the following: a. **Significant impairment**, **where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activit*ies*.** b. **A reasonable probability of significant deterioration in an important area of life functioning**.

AND

- The beneficiary's condition as described in paragraph (1) is **due to** either of the following: a. **A diagnosed mental health disorder**, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD). b. A **suspected mental disorder that has not yet been diagnosed.**

Criteria for Beneficiaries under 21

- Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:
- **The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by** any of the following: **scoring in the high-risk range under a trauma screening tool approved by the department**, **involvement in the child welfare** system, **juvenile justice** involvement, or experiencing **homelessness**.
- ***OR***
- The beneficiary **meets both of the following requirements** in a) and b), below:
- The beneficiary has at least one of the following: i. A **significant impairment** ii. A reasonable **probability of significant deterioration** in an important area of life functioning iii. **A reasonable probability of not progressing developmentally** as appropriate. iv. **A need for specialty mental health services, regardless of presence of impairment**, **that are not included within the mental health benefits that a Medi-Cal managed care plan** is required to provide.

Under 21 Criteria Continued

AND

- The beneficiary's condition as described in subparagraph (2) above is due to one of the following:

i. **A diagnosed mental health disorder**, according to the criteria of the current editions of the DSM and the ICD.

ii. **A suspected mental health disorder that has not yet been diagnosed**.

iii. **Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional**

The State Defines Juvenile Justice Involvement as follows:

- The beneficiary has ever been **detained or committed to a juvenile justice facility**, or is **currently under supervision** by the juvenile delinquency court and/or a juvenile probation agency.
- Beneficiaries who **have ever been in custody** and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition.
- Beneficiaries **on probation**, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

The State Defines Homelessness as follows:

- The beneficiary meets the definition established in McKinney-Vento Homeless Assistance Act.15

  (A) individuals who lack a fixed, regular, and adequate nighttime residence

  (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals

- **youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings** children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children

The State Defines Involvement in child Welfare as follows:

- The beneficiary has an open child welfare services case, or is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement or the beneficiary is **a child whose adoption or guardianship occurred through the child welfare system**.
- A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a **family maintenance case** (pre-placement or post-reunification), including both **court ordered and by voluntary agreement**.
- A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Trauma Screening Tools

- The **Pediatric ACES** and **Related Life-Events Screener (PEARLS)** tool is one example of a standard way of measuring trauma for children and adolescents through age 19.
- The **ACE Questionnaire** is one example of a standard way of measuring trauma for adults beginning at age 18.
- DHCS will explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement.
- **MHPs are not required to implement the tool** until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

Questions and Answers

For youth who do not have a diagnosis, can providers use any Z code (including those reflecting Social Determinants of Health)?

No. DHCS recommends using options available in the CMS approved ICD-10 diagnosis code list, including "Other specified", "Unspecified" disorders," or "Factors influencing health status and contact with health services". (i.e., Z codes). The State has also previously recommended the use of Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out" which can be used when providing crisis intervention, crisis stabilization, or during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

Questions and Answers

Is there a time limit to how long you can use a Z code?

BHIN 21-073 does not indicate a time limit on the use of the Z code. However, the intent of this guidance is to remove barriers to care by not requiring a mental health diagnosis as a "prerequisite for access to covered SMHS." The guidance is not removing the requirement to provide a thorough assessment and a diagnosis when treating a beneficiary, as these are critical components of treatment that inform the services that are provided. If a Z code is being used, the County's expectation is that the documentation clearly indicates the steps the provider is taking in determining the diagnosis.

The portion of BHIN 20-043 that limits SMHS to a list of DHCS included ICD-10 diagnoses is superseded by this BHIN, effective January 1, 2022, except for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance.

Questions and Answers

What if someone presents with a Substance Use Disorder (SUD) diagnosis at the beginning of treatment?

The new guidance noted below allows providers to treat beneficiaries when there are co-occurring substance use issues. However, the primary focus of treatment within SMHS remains the MH disorder. If a beneficiary is assessed to have a primary SUD condition, they should be referred to the SUD system of care.

"A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service is no longer excluded if ☐ Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process. ☐ The prevention, screening, assessment, treatment, or recovery service is not included in an individual treatment plan. ☐ The beneficiary has a co-occurring substance use disorder."

However, "a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system."

Questions and Answers

Because youth can qualify for services based on their experience of trauma, regardless of whether they have a diagnosis, DHCS has indicated youth who are at risk of a mental health condition can continue to receive services as long as the care is medically necessary, regardless of whether they ever receive a diagnosis. Would you agree?

One of the indicators for establishing the criteria for beneficiary access (Medical Necessity) on admission and ongoing is that the beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

If this is established, then criteria is met without a diagnosis. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. DHCS recommends using options available in the CMS approved ICD-10 diagnosis code list, including "Other specified", "Unspecified" disorders," or "Factors influencing health status and contact with health services". (i.e., Z codes).

As noted earlier, the guidance is not removing the requirement to provide a thorough assessment and diagnosis that will inform the clinical care. In the scenario mentioned, the treating provider is expected to continue to assess the beneficiary's condition, review their history, collect collateral information, etc. and to document a diagnosis if/once one is identified.

Questions and Answers

If treatment services can be provided before the assessment and Client Plan have been completed, could they also be provided in periods between authorization, such as if a cycle ends in December but the new assessment and Client Plan aren't completed until Jan 5th. Would the services between Dec 31 and Jan 5th be disallowed if not waste fraud or abuse?

No. Per the new guidance, clinically appropriate and covered MH prevention, screening, assessment, treatment or recovery services are no longer excluded if the services are not included in an individualized Client Plan. The only disallowances will be based on fraud, waste or abuse. The State plans to disseminate it's "Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023" document on October 2022 at which time we will have more clarity regarding the specific circumstances that would lead to disallowances.

Questions and Answers

Please confirm that chart reviews and disallowances are suspended until a new chart review checklist can be developed that fully reflects the new eligibility guidance.

The State has not given counties permission to suspend or postpone audits of agencies. At this time counties are required to continue with audits.

Summary

- The CalAIM initiative is an ambitious effort that will transform the Medi-Cal delivery system.
- Information and guidance related to the CalAIM changes are being shared by the State in phases. Although the intent of the guidance and policies are often clear, many questions come up related to their operational impact.
- ACBH is committed to learning about the changes and communicating them with our providers as information becomes available and questions are clarified.
- An FAQ document will be published on the ACBH Provider Website and updated to keep all stakeholders informed.

We appreciate your patience and partnership as we work together to implement this exciting DHCS initiative.

- Please continue to send your questions through the QA TA box: QATA@acgov.org

thank you.

Contact QATA@acgov.org for more information

alameda county behavioral health

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