



Introduction to CalAIM

Frequently Asked Questions

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Additional Resources for Staff

QM Website	Your one stop shop for QM resources. Click on the CalAIM tab for information specific to CalAIM.
HS_BHRS_ASK_QM@smcgov.org	Got questions? Send them to Ask QM.
Department of Health Care Services	If you want to read more about DHCS' CalAIM efforts.

Purpose of this Document

The purpose of this document is to help staff better understand the changes under CalAIM. QM will continue to update this document with more guidance.

If you have any additional questions, please send to HS_BHRS_ASK_QM@smcgov.org.

General Questions about CalAIM

1. What is CalAIM?

CalAIM stands for California Advancing and Innovating Medi-Cal (CalAIM). It is a multi-year initiative by the State Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms across the Medi-Cal program.

2. Who is CalMHSA?

The California Mental Health Services Authority (CalMHSA) is an organization that has been working since 2009 to provide administrative and fiscal support to counties in order to improve mental health services. DHCS has contracted with CalMHSA to provide additional support and develop policies and resources based on the DHCS Behavioral Health Information Notices (BHIN) related to CalAIM. Many of the resources that you will see regarding CalAIM will come from a variety of sources including CalMHSA, DHCS, and BHRS QM.

Access to SMHS vs. Medical Necessity

3. What's the difference between "Access to SMHS" Criteria and "Medical Necessity" Criteria?

There are two major changes to what was previously referred to as "Medical Necessity Criteria." One of these changes is that an "included diagnosis" is no longer required to bill for services. The other major change is that CalAIM now breaks down what was previously known as "Medical Necessity Criteria" into two parts: "Access to SMHS" and "Medical Necessity."

The new criteria to Access SMHS refers to an individual's eligibility for Specialty Mental Health Services (SMHS). Medical Necessity now refers to determining which services are appropriate for the client to receive, and includes determining if the client requires the level of service provided by BHRS or if the client would be better served in another level of care (e.g. HPSM for mild-to-moderate services).

In other words, the Access Criteria gets the individual in the door to receive SMHS, and Medical Necessity will be used to determine what types and level of service the client should receive.

There are different criteria for Adults and Youth. For more specifics on the Access criteria and Medical Necessity criteria for each age group, please refer to the tables located at the end of this document. Quick Links to each table are located below:

Quick Links to each criteria list:

Table 1: [Access to SMHS Criteria for Adults](#)

Table 2a: [Access to SMHS Criteria for Youth](#)

Table 2b: [Population Categories for Youth Access to SMHS](#)

Table 3: [Medical Necessity Criteria for SMHS \(Includes both Youth and Adults\)](#)

Diagnosis

4. Now that the Included Diagnosis list is no longer a requirement, does that mean any diagnosis in the ICD-10/DSM-V can be used?

The types of mental health disorders in the ICD-10/DSM-V that can be used for claiming purposes has expanded significantly, and now also includes Z codes and unspecified disorders. (Remember, DSM-V diagnoses have a corresponding ICD-10 code). However, only those diagnoses that are considered a mental health disorder* can be used to claim for SMHS.

***Please note that 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. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described below.

5. If I give my client a Z code while I continue to assess, do I have to change it at some point or can I continue to provide services with just a Z code?

A Z code alone could be utilized while a clinician takes time to gather information about the individual's presenting needs and determine the most appropriate diagnosis and next steps. However, the Z code should not be utilized indefinitely (given the access to SMHS criteria for individuals 21 and up) as it may be challenging to justify ongoing medical necessity without a formal diagnosis of a “mental health disorder” (also known as an “F-Code” diagnosis, such as Depressive Disorder or Schizophrenia).

However, in some settings or for some service types, particularly with children and youth, services can more easily be justified based only on Z codes.

6. In cases where services are provided due to a suspected mental health disorder not yet diagnosed, what codes can be utilized?

In cases where services are provided due to a suspected mental health disorder not yet diagnosed, the codes below can be utilized:

Diagnosis codes for use by LPHAs	Diagnosis Codes for Use by All Providers*
<ul style="list-style-type: none"> • Any clinically appropriate code • Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out) • “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services” 	<ul style="list-style-type: none"> • Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances) <p><i>*May be used during the assessment period prior to diagnosis; do not require supervision of a Licensed Practitioner of the Healing Arts (LPHA)</i></p>

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7. If I have been treating a client due to a suspected mental health disorder, but ultimately determine that they do not have a diagnosis, will the services I provided and billed for be disallowed?

Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

Assessment and Treatment Services

8. Has the timeframe for when assessments are due changed?

The time period for providers to complete an initial assessment and subsequent reassessments is up to clinical discretion; however, providers shall complete them within a reasonable time and in accordance with generally accepted standards of practice*. Any delays in completing the assessment should be documented in a progress note (e.g., client misses appointments, client's presentation is complex, etc.).

**QM's Recommendation: The generally accepted standards of practice have been to complete the Initial Assessment within 60 days, and the Reassessment every 3 years (or sooner, if clinically appropriate). However, under CalAIM there has been more flexibility granted in the timeline for completing the assessment as long as it is clinically appropriate, and the reason is documented in a progress note.*

9. I've heard that treatment plans are no longer required. Is this true?

This is partially true. DHCS has removed the state requirement for a treatment plan for most services and replaced the Treatment Plan with a Problem List. However, the services listed below still require treatment planning due to federal regulations. More guidance will be forthcoming about how to document the treatment plans for these services:

- Targeted Case Management (TCM)
- Peer Support Services
- Intensive Home Based Services (IBHS)
- Therapeutic Foster Care (TFC)
- Intensive Care Coordination (ICC)
- Therapeutic Behavioral Services (TBS)
- Services provided in Short-Term Residential Therapeutic Programs (STRTPs)
- Services provided in Psychiatric Health Facilities (PHF)
- Services provided in Special Treatment Programs within Skilled Nursing Facilities (STP-SNF)
- Services provided in Mental Health Rehabilitation Centers (MHRCs)
- Services provided in Social Rehabilitation Programs.
- Narcotic Treatment Programs (NTP)

Access to SMHS Criteria for Adults

SMHS Access Criteria for ADULTS	
For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet both of the following Criteria, (1) AND (2) below :	
Criteria (1)	
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 activities, OR	<input type="checkbox"/>
b. A reasonable probability of significant deterioration in an important area of life functioning.	<input type="checkbox"/>
Criteria (2)	
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 and the International Statistical Classification of Diseases and Related Health Problems, OR	<input type="checkbox"/>
b. A suspected mental disorder that has not yet been diagnosed.	<input type="checkbox"/>

Access to SMHS Criteria for Youth

SMHS Access Criteria for YOUTH	
<p>For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet either of the following Criteria, (1) OR (2) below:</p>	
Criteria (1)	
<p>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:</p>	
<p>a. Scoring in the high-risk range under a trauma screening tool approved by the department, OR</p>	<input type="checkbox"/>
<p>b. Involvement in the child welfare system, OR</p>	<input type="checkbox"/>
<p>c. Juvenile justice involvement, OR</p>	<input type="checkbox"/>
<p>d. Experiencing homelessness</p>	<input type="checkbox"/>
Criteria (2)	
<p>The beneficiary meets both of the following requirements in a) AND b), below:</p>	
<p>a. The beneficiary has at least one of the following:</p> <ul style="list-style-type: none"> 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 SMHS, 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. 	<input type="checkbox"/>
<p>b. The beneficiary's condition as described above (Criteria 2a) is due to one of the following:</p> <ul style="list-style-type: none"> i. A diagnosed mental health disorder*, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. 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. 	<input type="checkbox"/>
<p><i>If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is <u>not</u> necessary to establish that the beneficiary also meets the criteria in (2) above.</i></p>	

Population Categories for Youth Access to SMHS

10. For SMHS Access Criteria (1) for Youth, how is the population for each population category defined?

Population Categories	
<p>For use with Criteria (1) for beneficiaries under 21 years of age.</p> <p>Please use the criteria below to determine if a beneficiary under the age of 21 years falls under any of the following population categories:</p>	
Child Welfare Involvement	
A child can have involvement in child welfare whether the child remains in the home or is placed out of the home. A beneficiary who meets any of the criteria below is considered to have Child Welfare involvement:	
1) Has an open child welfare services case, meaning: <ul style="list-style-type: none"> 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 	<input type="checkbox"/>
2) 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 with the provision of services under a prevention plan	<input type="checkbox"/>
3) Is a child whose adoption or guardianship occurred through the child welfare system	<input type="checkbox"/>
Juvenile Justice Involvement	
The beneficiary is considered to fall under this category if the beneficiary:	
1) Has ever been detained or committed to a juvenile justice facility, or	<input type="checkbox"/>
2) Is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency, or	<input type="checkbox"/>
3) Has 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, or	<input type="checkbox"/>
4) Is on probation, or has 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 is otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency	<input type="checkbox"/>

Table 2b: Population Categories for Youth

Experiencing Homelessness	
The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. ¹³ Specifically, this includes beneficiaries who fall under either criteria A or B below:	
A. Individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act);	<input type="checkbox"/>
B. Children/Youths who meet any of the following criteria:	
(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;	<input type="checkbox"/>
(ii) Children and youths 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 (within the meaning of section 103(a)(2)(C));	<input type="checkbox"/>
(iii) Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings;	<input type="checkbox"/>
(iv) Migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).	<input type="checkbox"/>

Medical Necessity Criteria for SMHS

Medical Necessity Criteria for SMHS	
<p><i>*Please keep in mind that for either age group below, federal guidance from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition, and are thus medically necessary and covered as EPSDT services.</i></p> <p><i>Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary’s presenting condition.</i></p>	
Clients under 21 years of age	Clients 21 years and older
<p>For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.</p>	<p>For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.</p>