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CalAIM: No Wrong Door for Mental Health Services Practical Guide to Key Implementation Scenarios

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Background

Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Service (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and provide beneficiaries the right care in the right place at the right time to improve beneficiary outcomes.

No Wrong Door is one of the CalAIM policies aimed at achieving these goals. The purpose of the No Wrong Door policy is to ensure that Medi-Cal beneficiaries receive mental health services without delay regardless of where they initially seek care, and that beneficiaries can continue to see the provider with whom they have built a trusted relationship. DHCS released the No Wrong Door for Mental Health Services policy in March 2022 via BHIN 22-011 and APL 22-005. Medi-Cal Managed Care Plans (MCPs) and County Mental Health Plans (MHPs) have joint responsibility for implementing the No Wrong Door policy.

Purpose

The scenarios presented below were developed in response to questions received from stakeholders regarding the CalAIM "No Wrong Door" for Mental Health Services policy which went live July 1, 2022.

While these scenarios provide examples of how MCPs and MHPs should think about assessment, service provision, and coordination under the "No Wrong Door" policy, ultimately each case must be considered on an individual basis and based on clinical judgment. It is the responsibility of the MCPs and MHPs to coordinate and define collaboration strategies within their Memorandum of Understanding (MOU) to provide medically necessary services to each beneficiary.

Document Guide

Topic	Scenario	Questions Addressed
Assessment	1	How long should the assessment process take?
	2	Can services be claimed during the assessment process? How can providers bill during the assessment process?

Topic	Scenario	Questions Addressed
Post Assessment/ Beneficiary Diagnosis	3	What if the beneficiary was receiving specialty mental health services before they were assessed and determined to not meet access criteria?
	4	What if the beneficiary meets both non-specialty mental health services and specialty mental health services criteria?
	5	What if the beneficiary has co-occurring mental, physical and/or substance use-related conditions?
Mental Health Plan and Managed Care Plan Coordination	6	How will DHCS ensure MHPs and MCPs are coordinating and provide oversight? How should MHPs and MCPs ensure non-duplication?
Continuity of Care	7	How does federal Continuity of Care policy apply to No Wrong Door?

Scenario 1: Determining Length of Assessment Period
MCPs and MHPs should share their policies and procedures, and coordinate where possible around appropriate assessment period length. The policies and procedures should ensure flexibility to account for individual beneficiary's needs.

DHCS is not prescribing the length of the assessment period. DHCS received feedback from stakeholders that the assessment period should be tailored to the beneficiary's presentation of symptoms and determined based on clinical expertise. As described in BHIN 22-019, consistent with managed care practices, the time period for providers to complete an initial assessment and subsequent assessments for Specialty Mental Health Services (SMHS) is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.[1]

Scenario 2: Claiming for Services Provided During the Assessment
A beneficiary is not required to have a mental health diagnosis to access covered SMHS. For adults and youth, this includes services provided prior to determining a diagnosis and clinically appropriate and covered services during the assessment process. For youth under 21, this also includes beneficiaries who meet criteria for access to services due to having a condition placing them at high risk for a mental health disorder due to the experience of trauma. Please refer to BHIN 21-073 for additional information.

Similarly, a beneficiary is not required to have a mental health diagnosis to access Non-Specialty Mental Health Services (NSMHS) covered by MCPs. As described in APL 22-006 and the Medi-Cal Provider Manual, adults and youth with potential mental health disorders not yet diagnosed are able to receive covered NSMHS. In addition, youth

[1] Assessment requirements for the Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) are different and can be found in BHIN 21-071 and 21-075.

under 21 are able to receive covered NSMHS regardless of the level of distress or impairment, or the presence of a diagnosis, to the extent eligible under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Billing and Claiming

To support providers and plans, DHCS issued BHIN 22-013 on how to bill during the assessment phase prior to a diagnosis being established, including guidance on the appropriate ICD-10 codes to utilize during assessment for SMH, DMC, or DMC-ODS services.

Medi-Cal claims, including SMHS, DMC, and DMC-ODS claims during the assessment process, must include an ICD-10 diagnosis code. The ICD-10 diagnosis codes enable a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP) to claim when services are provided due to a suspected mental health disorder that has not yet been diagnosed. LPHAs and LMHPs can use any appropriate ICD-10 codes. Examples of codes that may be appropriate during the assessment process are codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.” ICD-10 codes Z55-Z65 may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a LPHA or LMHP, as outlined in BHIN 22-013. Additional information about coding during the assessment phase of a beneficiary’s treatment can be found in BHIN 22-013, MCPs are encouraged to use coding consistent this guidance, if appropriate.

Scenario 3: Beneficiary Meets Non-Specialty Mental Health Criteria and Does Not Meet SMHS Criteria or Vice Versa

During the assessment period, the beneficiary’s services are covered and reimbursable regardless of whether the assessment is provided by a NSMHS provider and billed to the MCP or a SMHS provider and billed to the MHP. Clinically appropriate and medically necessary services may be provided to beneficiaries and are reimbursable during the assessment period.

If a beneficiary is determined to not meet SMHS access criteria but to instead meet criteria for NSMHS, the MHP must coordinate with the MCP or a fee-for-service (FFS) provider[2] of NSMHS to transition care to a NSMHS provider, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. The SMHS or MHP referring the beneficiary directly to an MCP NSMHS network provider, and subsequently notifying the MCP, is sufficient to meet the requirement for coordinating with the MCP.

Scenario 4: The Beneficiary Meets Both SMHS and NSMHS Criteria

How MCPs and MHPs coordinate around a beneficiary who meets both SMHS and NSMHS criteria should be case specific and based on clinical judgement. The MCP and MHP must coordinate to determine what is in the best interest of the client, with a focus

[2] A list of FFS providers is available at https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider.

on individual clinical need and maintaining established therapeutic relationships with treating providers. The beneficiary has the right to receive medically necessary services at a lower level of care (as clinically appropriate) if they choose.

In some cases, the beneficiary will need services from both plans. In these cases, services can be provided simultaneously by the MCP and MHP, if those services are coordinated and not duplicative (for example, a beneficiary may only receive psychiatry services in one network, but not both networks. A beneficiary may only access individual counseling in one network, but not both networks). Such decisions should be made via a patient-centered shared decision-making process. Beneficiaries receiving NSMHS who meet both NSMHS criteria and SMHS criteria may continue receiving NSMHS unless and until the treating clinician recommends SMHS exclusively and the beneficiary has been transferred to an MHP provider who accepts the care of the recipient.

Example Case
A youth with child welfare involvement is receiving individual psychotherapy as a NSMHS from an MCP provider, and a need for psychotropic medication is identified. The MCP provider provides a referral to the MHP for medication support services from a prescriber specializing in child and adolescent psychiatry. The youth may receive prescriptions and medication support services from the MHP but opts to continue receiving therapy from the MCP provider with whom they have established a trusted relationship.

Scenario 5: The Beneficiary Has Co-occurring Conditions
If an individual meets NSMHS and/or SMHS criteria, regardless of other diagnoses (e.g., diabetes, congestive heart failure, eating disorders, developmental disabilities, dementia, etc.) the MCP and/or MHP must provide the beneficiary with medically necessary clinically appropriate NSMH and/or SMH services, respectively. If they meet NSMHS criteria but not SMHS criteria, they should be referred to the MCP or fee-for-service provider to receive NSMHS.

Specialty substance use disorder (SUD) services are covered through county Drug Medi-Cal or Drug Medi-Cal Organized delivery systems. If the beneficiary has co-occurring mental health and substance use needs, the MHP or MCP should make a referral to the county for specialty SUD services as needed.

Scenario 6: Coordination Between MCPs and MHPs
In general, coordinating appropriate and effective treatment for beneficiaries who need services in both delivery systems involves unique complexities and is a shared responsibility between MCPs and MHPs. MCPs and MHPs should review the CalAIM Data Sharing Authorization Guidance, which outlines how entities can share data in compliance with federal and state privacy laws. This resource includes scenarios illustrating how data may be shared to ensure coordination and non-duplication. DHCS is developing additional data sharing guidance to specifically support MCPs and MHPs with implementing the “No Wrong Door” policy, and this technical assistance document will be updated to reflect the forthcoming guidance.

In addition, MCPs and MHPs should develop their MOU to clarify how care coordination is operationalized and how the plans will ensure that services are appropriate and not duplicated, including whether the MHP and MCP will accept and/or review assessments from each other. MHPs and MCPs will need to submit revised MOUs to DHCS that consider the No Wrong Door policy. The updated MOU Requirements guidance that reflect CalAIM policy initiatives, including No Wrong Door, is forthcoming in 2022.

Providers are encouraged to reference BHIN 22-009 and APL 22-003 which provide guidance for MCPs and MHPs related to coordinating treatment for beneficiaries with eating disorders. Eating disorders are complex conditions involving both physical and psychological components and effective treatment often requires services from both the MCP and MHP.

Scenario 7: Applying Continuity of Care

Continuity of Care[3] applies to the "No Wrong Door" Policy. The No Wrong Door policy does not supersede existing Continuity of Care requirements, as outlined per BHIN 18-059, APL 18-008, and 42 C.F.R. 438.62.

[3] The federal Continuity of Care rule mandates that states establish transition of care policies to ensure that during a transition between delivery systems or between plans beneficiaries have access to services when "in the absence of continued services, [the beneficiary] would suffer serious detriment to their health or be at risk of hospitalization or institutionalization." See 42 CFR 438.62(b) at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.62.