Behavioral Health Department
Alameda County Health

Frequently Asked Question (FAQ) Module 2

Specialty Mental Health Services Early Intervention (SMHS EI) Model

1. What is the EI model?

   An Early Intervention (EI) program shall include the following components:
   - **Outreach**,
   - **Access and Linkage,**
   - **Treatment Services** for the purpose of preventing mental health illnesses and substance use disorders from becoming severe.
   - Services may include first episode psychosis programming and services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impact of suicide.

   The State Department of Health Care Services (DHCS) may require a county to implement specific evidence-based and community-defined evidence practices. While the final regulatory language from DHCS regarding Early Intervention Services has not been finalized, it should be noted that under SMHS there are multiple activities and services that are considered early intervention including but not limited to: targeted outreach, training on early identification, peer support, assessment, brokerage, linkage to services, crisis stabilization, group services and treatment. ACBHD EI Model is subject to review and potential revisions based on additional DHCS guidance.

2. Is EI being integrated into SMHS or is it just being housed in SMHS?

   EI is being integrated into the SMHS continuum of care, and more specifically begins the continuum. Due to the bifurcation of Medi-Cal mental health services, with mild-to-moderate conditions being the responsibility of Managed Care Plans (MCP) and moderate-to-severe conditions being the responsibility of Mental Health Plans (MHP), there is overlap in the two Plans for the moderate conditions. Within SMHS, EI services have been minimal due to current funding restrictions, however under BHSA regulations 51% of the Behavioral Health Services and Supports component are required to be allocated to EI services, with a specific service model. Per BHSA, EI services and supports are intended to prevent mental illness from becoming severe and disabling and to reduce health disparities. Service provision will include a full range of outreach, engagement, linkage, and treatment services.

   This is consistent with BHSA prioritization of Medi-Cal billable services; beginning in 2029 Counties will be given a billable services benchmark to attain and maintain.

3. Will it be possible to provide EI services without opening a case with the county (heavy lift)?

   No.

4. Will the criteria for opening a case expand to include the psychoeducational component of Early Intervention?

   Cases will not need to be open for psychoeducation activities to occur as part of targeted outreach. However, psychoeducation can also be included as a billable direct service activity once a case is open.

5. Should **ALL** PEI providers get an early start on completing the Medi-Cal checklist now if they want to transition becoming a Medi-Cal SMHS provider?

   No. ACBHD is still in an internal review process to determine the budget for EI services in FY 26/27 based on state revenue estimates. Additionally, ACBHD will be prioritizing programs for the transition that are currently operating in a similar EI model to that of the model under BHSA. While additional programs may be considered, ACBHD is starting this process with current programs functioning with a similar model in order to be prepared for the implementation of BHSA in July 2026. ACBHD believes this approach will be a significant and positive change to our beneficiaries.

6. Can early psychosis early intervention be provided in both Specialty Mental Health (SMH) and through the Mental Health Plans (MHP's)?

   ACBHD is the MHP for the Medi-Cal population with moderate to severe mental health needs and substance use disorders. Early psychosis programming may be included in an early intervention program as defined by DHCS. The Managed Care Plan (MCP) is the health insurance provider for individuals who have Medi-Cal. The MCP at their discretion can offer a variety of services including early psychosis programming for their client population. This decision on MCP services is not connected to ACBHD services.

7. Would current SMHS programs be adding another service program such that ACCESS would be the front door with new QA needed and most likely more staffing to maintain the QA and standards of this new program?

   The current opt-in opportunity is for existing Prevention and Early Intervention (PEI) providers who render early intervention components. Organizations that that have current SMHS and PEI contracts would be opting-in to transition their PEI program to SMHS EI program.

8. How will the population served be impacted if providers shift to billing Medi-Cal as a SMHS provider? Will the population have to shift from early intervention (EI) into moderate-to-severe to meet the criteria for Medi-Cal billing? How do we retain serving those who are in need of early intervention services?

   Under the Behavioral Health Services Act, 35% of funds must be allocated to the Behavioral Health Services and Supports (BHSS) component. Of this, 51% must be allocated to Early Intervention Services. While the regulatory language from the Department of Health Care Services (DHCS) regarding Early Intervention Services has not been finalized, the draft language states: Each county shall establish and administer an Early Intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health. An Early Intervention program shall include outreach, access and linkage, and treatment services for the purpose of preventing mental health illnesses and substance use disorders from becoming severe.

   Due to the regulatory language still being drafted, ACBHD is still in the process of finalizing the specific EI model that will be implemented under Specialty Mental Health Services (SMHS). However, it should be noted that under SMHS there are multiple activities and services that are considered early intervention including but not limited to: targeted outreach, training on early identification, peer support, assessment, brokerage, linkage to services, crisis stabilization, group services and treatment.

9. What is considered evidence based? Will cultural consideration be taken into consideration?

   Evidence-based practice guides programming planning and service delivery based on scientific evidence (data). Related approaches include community-informed practice and culturally competent practice. Many PEI programs use a combination of evidence-based, community-informed, and culturally competent practices and curricular resources. All these practices have been and will continue to be valued core elements of BHD's EI model under BHSA. Please see the ACBHD Practice Guidelines.

10. Will there be a centralized entry point/process for services at BH as a whole?

    While the EI model is still being reviewed internally it is ACBHD's intention to create a low barrier entry point for clients. As an example, we are anticipating that clients will be able to be referred through a variety of pathways including, but not limited to the ACBHD ACCESS program, parents/family/caregivers, schools, health care agencies, juvenile justice system and self-referral.

11. Is it possible that some of the patients are being served by the MHPs now?

    If clients are presently being served by either the MHP (which in this county is ACBHD) or the Managed Care Plan (MCP) then they should continue receiving services with their current provider.

12. Do the eligibility criteria remain the current CalAIM criteria?

    Yes. With the CalAIM initiative, DHCS introduced a new concept called Access Criteria to remove unnecessary barriers to care by allowing treatment to begin prior to diagnosis, in cases where a diagnosis cannot be readily established. With the introduction of this concept, a diagnosis is no longer a prerequisite for accessing needed SMHS or DMC-ODS services. Services rendered in good faith are reimbursable prior to the determination of an official diagnosis.

    Access Criteria is different from Medical Necessity. Access Criteria looks at whether the individual is eligible to receive services, while Medical Necessity looks at whether the service provided is clinically appropriate to address the individual's condition.

    For detailed information regarding the access criteria, see policy 100-3-1 Criteria for Beneficiary Access to SMHS. Additionally, ACBHD has created this reference guide that can be used for providers to screen for access criteria: Behavioral Health Screening Tool for Outpatient Services.pdf

13. What are the CalAIM criteria for medical necessities?

    Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

    For individuals under 21 years of age, a service is "medically necessary" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services 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.

Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate mental health condition. Services that sustain, support, improve, or make mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT (Early and Periodic Screening, Diagnostic and Treatment) services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

14. How many will have to be diagnosis? Can early intervention be provided to those without a diagnosis?

A diagnosis is no longer a prerequisite for accessing needed SMHS or DMC-ODS services. Services rendered in good faith are reimbursable prior to the determination of an official diagnosis. Documentation in the medical record must initially demonstrate that the beneficiary meets the specific access criteria for each delivery system. If a diagnosis cannot be immediately established, specific Z codes are accepted to allow for billing and the start of a Problem List.

15. Does history of trauma suffice for treatment under EI?

Yes. Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for 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**

(2) The beneficiary meets both of the following requirements in a) and b), below:

a. 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. AND

b. 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 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.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

16. Does EI only start after a pathology has been identified?

    With the introduction of this concept, a diagnosis is no longer a prerequisite for accessing needed SMHS or DMC-ODS services. Services rendered in good faith are reimbursable prior to the determination of an official diagnosis.

    For detailed information regarding the access criteria, see policy 100-3-1 Criteria for Beneficiary Access to SMHS. Additionally, ACBHD has created this reference guide that can be used for providers to screen for access criteria: Behavioral Health Screening Tool for Outpatient Services.pdf

17. Does there have to be a BH diagnosis, or can z codes be used?

    Z codes can be used. Per Welfare and Institutions Code section 14184.402(f)(1)(A), 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. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. These include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes).
    Reference:13-3_ACBHD_Diagnosis_and_Code_Guidance.

Scope of Practice

18. Can EI be provided by non-licensed staff?

    Please refer to the Scope of Practice document that is published in section 12 of the QA Manual for details of what services can be provided and claimed to Medi-Cal by non-licensed staff.

19. Will staff engaged in EI need CANS and ANSA certification?

    Staff members completing the CANS must have a-Praed Foundation CANS Certification. Additionally, they need to have adequate knowledge and clinical understanding of the beneficiary to comprehensively complete all CANS domains.

Billing and Codes

20. Can we get reimbursement for work with collaterals (culturally appropriate work, work with youth and families?

    Yes. Per CalAIM payment reform changes, collateral is no longer a distinct service activity. Instead, collateral refers to significant support persons in the member's life. Services provided to collaterals may only be for the purpose of the member's treatment. Services provided to collaterals include Assessment, Rehabilitation, Treatment Planning, Peer Support, Targeted Case Management, Crisis, or Therapeutic Foster Care.

When providing services to a member's significant support person, select the service code that most closely fits the intervention provided for the purposes of the member's treatment and make clear in a progress note that the service was provided to a collateral contact. For example, if a clinician gathers assessment information about a member from their caregiver, they will use a suitable assessment code to report that activity. Per 9 CCR 1810.250, therapy codes require that the members be present for the service activity. Note that some code descriptions clearly describe the service as occurring with the member present. Those codes should not be used to report services provided to collaterals. Most HCPCs, however, are silent as to whether the member is required to be present or not. It is appropriate to use these codes when the member is not there so long as they are the codes that describe the service provided. For more information on this topic please go to the Short Doyle Medi-Cal Billing Manual: MedCCC - Library

Medi-Cal Quality Assessment, Performance Improvement, and Data Collection

21. What quality measures will be required?

    ACBHD does not anticipate any additional quality measures outside of the County-to-Provider boilerplate contract. Alameda County staff are responsible and accountable for Department of Health Care Services (DHCS) quality measure requirements (i.e. data collection, monitoring, reporting, and improvement). Quality measure data largely relies on encounter/claims data, with the former reliant on complete and timely direct service provider service entries in our billing and claiming system (i.e. SmartCare).

22. Will providers need to go through the CQRT process?

    Yes, all Specialty Mental Health Services (SMHS) Medi-Cal requirements apply.

Financial Support Questions

23. If MAA and SMH billing is not projected to cover actual costs, especially in the first year, after the pilot period, then will the county make us whole?

    The cohort 1 group as well as all PEI providers will receive their normal allocation for FY 25/26. During this time period ACBHD will work with the providers to transition to the EI model which will be similar to the current PEI model under the Under Served Ethnic and Language Population (UELP) model. Depending on service utilization and billing practices, budgets will be adjusted in FY 26/27. ACBHD will work with EI providers during this transition period to ensure fiscal stability.