CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: XXX XX, 2026 Behavioral Health Information Notice No: 26-XXX
Supersedes: BHIN No. 22-016

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Behavioral Health Association
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California

SUBJECT: Authorization of Outpatient Specialty Mental Health Services (SMHS)

REFERENCE: Welfare and Institutions Code (W&I) sections 14197.1(b)[1] and 14184.402(i)[2]

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[1] W&I section 14197.1, subdivision (a) requires the department to ensure Medi-Cal mental health benefits are provided in compliance with the federal mental health parity regulations. Subdivision (b) authorizes the department to implement and interpret section 14197.1 by information notice.

[2] W&I Code section 14184.402, subdivision (a) requires the department to ensure that all medical necessity determinations forcovered specialty mental health services and substance use disorder services are made in accordance with W&I Code section 14059.5. Subdivision (i) authorizes the department to implement and interpret section 14184.402 by information notice until regulations are promulgated.

PURPOSE:
To ~~communicate to~~ provide county Mental Health Plans (MHPs) with updated guidance ~~federal requirements~~ related to the authorization of specialty mental health services (SMHS), except for psychiatric inpatient hospital and psychiatric health facility services. Including policy changes ~~to the Department of Health Care Services has made~~ to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

BACKGROUND:
Pursuant to existing state and federal requirements, MHPs are required to operate a utilization management (UM) program that ensures ~~beneficiaries~~ members have appropriate access to SMHS.[3] The UM program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal ~~beneficiaries~~ members prospectively, such as through prior or concurrent authorization procedures, or retrospectively through retrospective authorization procedures.[4] Compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for the individuals or entities to deny, limit, or discontinue medically necessary services to a ~~beneficiary~~ member.[5] MHPs must also establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to ~~beneficiaries~~ members.[6] This program must include mechanisms to detect both underutilization and overutilization.[7] Additionally, MHPs must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.[8]

MHPs are responsible for certifying that claims for covered SMHS meet federal and state requirements.[9] MHPs provide or arrange for the provision of SMHS to Medi-Cal ~~beneficiaries~~ members that meet criteria for SMHS, and approve and

[3] Cal. Code Regs., tit. 9, § 1810.440(b); 42 C.F.R., § 438.210, subd. (b)(1),(b)(2)
[4] See MHP Contract, Ex. A, Att. 6.1 B.
[5] 42 C.F.R., § 438.210(e)
[6] 42 C.F.R., § 438.330(a)(1)
[7] 42 C.F.R., § 438.330(b)(3)
[8] 42 C.F.R., § 438.608(a)(1)
[9] MHP Contract, Ex. B, Sec. 5.B; 42 C.F.R, § 433.51; Cal. Code Regs., tit. 9, §1840.112

authorize these services according to state requirements.[10] MHPs may place appropriate limits on a service based on medical necessity, or for the purpose of utilization control, provided that the limits are consistent with the State Plan, waiver documents, the MHP contract, state and federal law and guidance, including the policies described below, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for ~~beneficiaries~~ members with ongoing or chronic conditions are authorized in a manner that reflects the ~~beneficiary's~~ member's ongoing need for such services and supports.[11] Further, MHPs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the ~~beneficiary~~ member.[12]

Parity Final Rule

On March 30, 2016, CMS issued the Parity Rule to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid ~~beneficiaries~~ members.[13] It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant limitations imposed for substantially all medical and surgical services within a benefit classification.[14] In addition, the Parity Rule prohibits an MHP from applying a non-quantitative treatment limitation (a requirement that limits the scope or duration of a benefit) to a mental health benefit unless the limitation is comparable to, and applied no more stringently, than it is applied to corresponding medical benefits.[15]

Welfare and Institutions Code (W&I) section 14197.1 requires DHCS to ensure that all covered mental health benefits and substance use disorder benefits, as those

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[10] See State Plan, section 3, Supplement 3 to Attachment 3.1-A, page 2c; section 3, Supplement 2 to Attachment 3.1-B, page 5
[11] 42 C.F.R., § 438.210 (a)(3)(i) and (a)(4)(ii)
[12] 42 C.F.R., § 438.210 (a)(3)(ii)
[13] 42 C.F.R., § 438.910(b)(1)
[14] 81 Fed. Reg., § 18390 (March 30, 2016); Medicaid Mental Health Parity Final Rule Federal Register: Federal Register
[15] 42 C.F.R., § 438.910(d)(1)

terms are defined in section 438.900 of Title 42 of the CFR, are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the CFR, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by CMS.[16]

Parity Assessment and Compliance Plan

The Parity Rule required DHCS to conduct an analysis of its delivery systems to determine if any applicable limitations exist.[17] This included a review of quantitative treatment limitations, financial and information requirements, and non-quantitative treatment limitations (NQTL). An NQTL is a limit on the scope or duration of benefits, which is not expressed numerically, such as prior authorization requirements. An NQTL may not be applied to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the classification.[18]

DHCS submitted its Parity Compliance Plan to CMS to demonstrate compliance with the Parity Rule by the implementation deadline of October 2, 2017, and updated October 2019. The Parity Compliance Plan outlines the findings from DHCS' parity assessment. During its assessment of the State's authorization policies across delivery systems, DHCS identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi-Cal Managed Care Plans (MCPs). Pursuant to DHCS' Parity Compliance Plan and federal Parity Rule requirements, the policies described in this BHIN address the inconsistencies for outpatient services and align the policies governing the MHPs with those governing the MCPs.

POLICY

[16] W&I, § 14197.1(a)
[17] 42 CFR, § 438.920(b)(1)
[18] 42 CFR, § 438.910(d)(1)

Pursuant to Welfare and Institutions Code section 14184.402(a), 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. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely 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 covered as EPSDT.

Requirements Applicable to Authorization of all SMHS

MHPs shall establish and implement written policies and procedures to address the authorization of SMHS in accordance with this BHIN.[19] Authorization procedures and utilization management criteria shall:

- Be based on SMHS access criteria, including access criteria for ~~beneficiaries~~ members under age 21 pursuant to the EPSDT mandate;
- Be consistent with current evidence-based clinical practice guidelines, principles, and processes;

Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;

- Be evaluated, and updated if necessary, at least annually; and,
- Be disclosed to the MHP's ~~beneficiaries~~ members and network providers.

MHPs shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is

[19] 42 CFR, § 438.210(b)(1)

made by a health care professional who has appropriate clinical expertise in addressing the ~~beneficiary's~~ member's behavioral health needs.[20] No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific clinical issues involved in the SMHS requested by a ~~beneficiary~~ member or a provider, may deny, or modify a request for authorization of SMHS for a ~~beneficiary~~ member for reasons related to medical necessity.[21]

A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.[22] If a MHP modifies or denies an authorization request, the MHP shall notify the ~~beneficiary~~ member in writing of the adverse benefit determination.[23] The notice to the ~~beneficiary~~ member shall meet the requirements pertaining to notices of adverse benefit determinations.[24]

MHPs shall notify the requesting provider in writing and give the ~~beneficiary~~ member written notice of any decision by the MHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.[25] The notice to the ~~beneficiary~~ member shall meet the requirements pertaining to notices of adverse benefit determinations.[26]

MHPs shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider

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[20] 42 CFR, § 438.910(d)(1)
[21] 42 C.F.R., § 438.210(b)(3)
[22] 42 C.F.R., § 438.210(b)(3)
[23] Welf. & Inst. Code 14197.1; Health & Saf. Code, § 1367.01(h)(4); 42 C.F.R. § 438.210(c)
[24] 42 C.F.R. § 438.210(c)
[25] See generally 42 C.F.R., §§ 438.210(c), 438.404; ~~MHSUDS IN 18-010E~~ BHIN 25-014
[26] 42 C.F.R., § 438.210(c); BHIN 25-014

when appropriate.[27]

MHPs must also comply with the following requirements:

- Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
- Maintain telephone access 24-hours a day, 7-days a week for providers to request expedited authorization of an outpatient service requiring prior authorization;
- ~~Prior authorization or MHP referral is required for the following services:~~
  - ~~Intensive Home Based Services~~
  - ~~Day Treatment Intensive~~
  - ~~Day Rehabilitation~~
  - ~~Therapeutic Behavioral Services~~
  - ~~Therapeutic Foster Care~~
- ~~No prior authorization shall be required for mental health assessment services, nor for outpatient services other than those listed above. See "Prior Authorization or MHP Referral for Outpatient SMHS" below.~~
- Disclose to DHCS, the MHP's providers, ~~beneficiaries~~ members and the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;
- Ensure the ~~beneficiary~~ member handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS,[28] and,
- Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

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[27] 42 C.F.R., § 438.210(b~~c~~)(1),; MHP Contract, Ex. A, Att 12; see also MHSUDS IN No., 18-010E
[28] 42 C.F.R., § 438.10(g)(2)(i-ii)
[28] ~~BHIN 225-009~~

All of the MHP's authorization procedures shall comply with the Parity Rule, in accordance with requirements set forth in Title 42 of the CFR, part 438.910.

Concurrent Review of Crisis Residential Treatment Services and Adult Residential Treatment Services

MHPs must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization. If the MHP refers a ~~beneficiary~~ member to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization. The MHP must then reauthorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the ~~beneficiary's~~ member's stay and based on ~~beneficiary's~~ member's continued need for services.

In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs may elect to authorize multiple days, based on the ~~beneficiary's~~ member's mental health condition, for as long as the services are medically necessary.

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to ~~beneficiaries~~ members shall be communicated to the ~~beneficiary's~~ member's treating provider within 24 hours of the decision[29] and care shall not be discontinued until the ~~beneficiary's~~ member's treating provider has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the ~~beneficiary~~ member. If the MHP denies or modifies the request for authorization, the MHP must notify the ~~beneficiary~~ member, in writing, of the adverse benefit determination. In cases where the MHP determines that care should be terminated (no longer authorized) or reduced, the MHP must notify the ~~beneficiary~~ member, in writing, of the adverse benefit determination prior to

[29] 42 CFR, § 438.10(g)(2)(iv).

discontinuing services.[30]

Prior Authorization or MHP Referral for Outpatient SMHS

MHPs must have policies in place regarding prior authorization and/or MHP referral requirements for outpatient SMHS as specified below:

MHPs shall not require prior authorization for the following services/service activities:

- Intensive Home-Based Services
- Crisis Intervention;
- Crisis Stabilization;
- Mental Health Services, including initial assessment;
- Targeted Case Management;
- Intensive Care Coordination;
- Peer Support Services; ~~and~~
- Medication Support Services;
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Individual Placement and Support (IPS) Supported Employment
- Clubhouse Services
- Parent-Child Interaction Therapy (PCIT)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- High Fidelity Wraparound (HFW)
- Enhanced Community Health Workers

Prior authorization or MHP referral is required for the following outpatient services:

- ~~Intensive Home Based Services~~
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care
- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)

For purposes of prior authorization, referral by the MHP to a contracted provider is considered to serve the same function as approving a request for authorization submitted by a provider or ~~beneficiary~~ member.

[30] HSC, § 1367.01(h)(3)

DHCS considered the following factors in determining which services will be subject to MHP referral or prior authorization requirements:

- Service type;
- Appropriate service usage, cost, and effectiveness of service and service alternatives;
- Contraindications to service and service alternatives;
- Potential fraud, waste, and abuse;
- Patient and medical safety; and,
- Other clinically relevant factors.

MHPs may require providers to request payment authorization for the continuation of services at intervals specified by the MHP (e.g., every six months). MHPs shall determine these intervals based on the criteria and guidelines detailed in this BHIN.

Outpatient Authorization Timeframe and Documentation Requirements

MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the ~~beneficiary's~~ member's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously jeopardize the ~~beneficiary's~~ member's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the ~~beneficiary's~~ member's health condition requires, but no later than 72 hours after receipt of the request for service.[31] The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

1. The ~~beneficiary~~ member, or the provider, requests an extension; or,
2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the ~~beneficiary's~~ member's interest.[32]

The MHP referral or prior authorization shall specify the amount, scope, and

[31] 42 C.F.R. §§ 438.404(c) and 431.213(c); BHIN 25-014
[32] 42 C.F.R., § 438.210(d)(2)

duration of treatment that the MHP has authorized. MHPs must document their determinations of whether a service requires MHP referral or prior authorization and maintain that documentation in accordance with Title 42 of the CFR, part 438.3(h).

If the MHP denies or modifies the request for authorization, the MHP must notify the ~~beneficiary~~ member, in writing, of the adverse benefit determination. In cases where the MHP terminates, reduces, or suspends a previously authorized service, the MHP must notify the ~~beneficiary~~ member, in writing, of the adverse benefit determination prior to discontinuing services. The ~~beneficiary's~~ member's notice shall meet the requirements to notify ~~beneficiaries~~ members of an adverse benefit determination.[33]

Retrospective Authorization Requirements

MHPs must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for ~~beneficiaries~~ members with other health care coverage pending evidence of billing, including dual-eligible ~~beneficiaries~~ members; and/or, ~~beneficiary's~~ member's failure to identify payer.

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

UTILIZATION REVIEW
Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. Nothing in

[33] 42 CFR, §§ 438.210(c), 438.404; MHP Contract, Ex. A, Att 12; see also MHSUDS IN No., 18-010E

this BHIN prohibits the MHPs from conducting utilization review and/or auditing activities in accordance with state and federal requirements. MHPs retain the right to monitor compliance with any contractual agreements between an MHP and the MHP's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with the MHP's obligations to DHCS, consistent with state and federal requirements. For example, the MHP may disallow claims and recoup funds if it determines a service, while authorized, was not furnished to the ~~beneficiary~~ member, or in other instances where there is evidence of fraud, waste, or abuse.

ONGOING MONITORING REQUIREMENTS

MHPs are responsible for demonstrating ongoing compliance with the Parity Rule and this BHIN. MHPs are required to maintain policies and procedures and to provide additional evidence of compliance with requirements upon request by DHCS and during compliance reviews and/or External Quality Review Organization reviews of each MHP. If, at any time, DHCS determines the MHP to be out of compliance with requirements outlined in this BHIN, the MHP will be required to submit a Plan of Correction, as well as evidence of correction, to the Department.

Questions regarding this BHIN may be directed to CountySupport@dhcs.ca.gov.

Sincerely, Original signed by
Ivan Bhardwaj, Division Chief
Medi-Cal Behavioral Health
Division