CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: February 2, 2026

ALL PLAN LETTER 26-002
SUPERSEDES ALL PLAN LETTER 22-006

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) for the provision or arrangement of clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F).[1] This APL outlines MCP responsibilities for referring and coordinating with County Mental Health Plans (MHPs) for the delivery of Specialty Mental Health Services (SMHS), including providing a list of Department of Health Care Services (DHCS)-approved youth trauma screening tools for the purposes of determining access criteria for the SMHS delivery system. This APL supersedes APL 22-006.[2]

BACKGROUND:

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to design a coherent plan to address Medi-Cal members' needs across the continuum of care, ensure that all Medi-Cal members receive coordinated services, and improve health outcomes. DHCS' goal is to ensure that Medi-Cal members have access to the right care, in the right place, at the right time. CalAIM changed the Medi-Cal Behavioral Health system to advance whole-person, accessible, high-quality care, including requirements regarding SMHS and NSMHS.[3]

Medical Necessity

[1] CMS-2333-F is available at: https://public-inspection.federalregister.gov/2016-06876.pdf?1459255519.
[2] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[3] For more information regarding CalAIM, please visit the CalAIM webpage at: https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx.

For individuals under 21 years of age, in accordance with California Welfare & Institutions Code (W&I) sections 14059.5 and 14184.402(a), a service is "Medically Necessary" or a "Medical Necessity" if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in 42 United States Code (USC) section 1396d(r)(5).[4]

The federal EPSDT mandate requires states to furnish to children under the age of 21 all Medically Necessary services, necessary to correct or ameliorate health conditions, including Behavioral Health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan, pursuant to 42 USC section 1396d(a), as incorporated in subdivision (b)(1) of W&I section 14059.5. 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 and, in the case of optional benefits by county or plan, irrespective of whether the MHP has opted to offer the benefit in question.

Consistent with the Centers for Medicare & Medicaid Services (CMS) guidance, Behavioral Health services need not be curative or completely restorative to "ameliorate" a Behavioral Health condition.[5] Services that sustain, maintain, support, improve, or make more tolerable a Behavioral Health condition are considered "ameliorating" the condition and are thus Medically Necessary and covered under the EPSDT mandate.

By contrast, for Members who are 21 years of age and older, a service is Medically Necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain.[6]

Access Criteria to the SMHS Delivery System

The SMHS delivery system access criteria described in Behavioral Health Information Notice (BHIN) 26-002[7] and W&I 14184.402(c) and (d) ensure that Medi-Cal members

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[4] State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml. See 42 USC section 1396d(r)(5) (requiring provision of all services that are coverable under section 1905(a) of the Social Security Act (42 USC section 1396d(a)) and that are 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). The USC is searchable at: https://uscode.house.gov/.

[5] CMS' federal EPSDT guidance can be found at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

[6] W&I section 14059.5,14184.402(a).

[7] BHINs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx.

receive Behavioral Health Services in the most appropriate delivery system for their needs.

DHCS'1915(b) Medi-Cal Waiver requires MCP Members in need of SMHS to access these services through the SMHS delivery system, also referred to as County MHPs.[8]

County MHPs are required to provide or arrange for the provision of SMHS for MCP Members who meet SMHS delivery system access criteria as outlined in BHIN No: 26-002.

BHIN 26-002 describes the various pathways for Members to meet access criteria to the SMHS delivery system. DHCS approved a list of youth trauma screening tools to identify if a Member under the age of 21 has a condition placing them at high risk for a mental health disorder due to the experience of trauma as specified in the Policy section below. If a Provider determines that a youth trauma screening tool is necessary to identify delivery system criteria, effective April 1, 2026, only DHCS-approved tools listed in Attachment A may be used.[9]

POLICY:

MCP Responsibility for NSMHS[10]

MCPs must provide or arrange for the provision of the following NSMHS:

- Mental health evaluation and treatment, including individual, group and family psychotherapy, and dyadic Behavioral Health Services.

[8] 1915(b) Waiver Information can be found at: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx.

[9] The use of a DHCS-approved trauma screening tool for youth to meet access criteria for SMHS is distinct from the administration of a clinical assessment. See Attachment A for a list of DHCS-approved youth trauma screening tools. As noted elsewhere in this guidance, not all trauma screening tools approved for this purpose are eligible for Medi-Cal reimbursement. Please see APL 23-017 and the Preventative Services section of the Provider Manual, to identify youth trauma screening tools eligible for reimbursement in the Medi-Cal managed care and Fee-For-Service (FFS) delivery systems under the Adverse Childhood Experiences screening services benefit. See Definitions section below for additional information.

[10] The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services, is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; See also W&I section 14184.402; More information regarding MCPs' responsibility for alcohol and substance use disorder (SUD) screening, referral, and services can be accessed in APL 21-014.

- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purpose of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs[11], supplies, and supplements.

MCPs must provide or arrange for the provision of NSMHS for the following populations:

- Members who are 21 years of age and older with mild-to-moderate distress, or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems (ICD);[12]
- Members who are under the age of 21, to the extent they are eligible for services through the EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;[13] and,
- Members of any age with potential mental health disorders not yet diagnosed.

In addition to the above requirements, MCPs must provide psychotherapy to MCP Members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a diagnosed mental health disorder. MCPs are also required to cover individual and/or group counseling sessions for pregnant and postpartum Members with specified risk factors for prenatal and postpartum depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. Details regarding NSMHS psychiatric and psychological services, including psychotherapy coverage, Current Procedural Terminology (CPT) codes that are

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[11] This is not inclusive of medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/.

[12] A neurocognitive disorder (e.g., dementia) is not a "mental health disorder" for the purpose of determining whether a member meets criteria for the provision of NSMHS. However, MCPs must provide or arrange for NSMHS for members with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.

[13] See 42 USC section 1396d(r)(5) (requiring provision of all services that are coverable under section 1905(a) of the Social Security Act (42 USC section 1396d(a)) and that are necessary to correct or ameliorate a condition, including a Behavioral Health condition discovered by a screening service, whether or not such services are covered under the State Plan.

covered, and information regarding eligible Provider types can be found in the Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services.

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies.

Consistent with state law, clinically appropriate and covered NSMHS are covered by MCPs even when:[14]

- Services were provided prior to determining a diagnosis, including appropriate and covered services during the assessment process.
- The prevention, screening, assessment, treatment or recovery services were not included in an individual treatment plan.
- The member has a co-occurring substance use disorder and/or is receiving Drug Medi-Cal or Drug Medi-Cal Organized Delivery System services.
- NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

More information regarding the above list and the No Wrong Door for Mental Health Services Policy can be found in APL 22-005.

MCPs must cover outpatient laboratory tests, drugs,[15] supplies, and supplements prescribed by mental health Providers in the MCP's Network and Primary Care Providers (PCPs), including physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions. The MCP may require that NSMHS for adults are provided through the MCP's Provider Network, subject to a Medical Necessity determination. Consistent with APL 23-001, the MCP must ensure that its Network is adequate to provide the full range of covered NSMHS to its Members.

MCPs must also cover and pay for emergency room professional services. This includes all professional physical, mental, and substance use treatment services, such as screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all

[14] See W&I section 14184.402(f).

[15] This is not inclusive of medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/.

services Medically Necessary to stabilize the MCP Member.[16] Emergency services include facility and professional services and facility charges claimed by emergency departments.

Assembly Bill 1316 (2024, Chapter 632) codified MCP responsibilities as outlined in the MCP boilerplate Contract. W&I section 14132.025(c)(1) requires that MCPs cover and reimburse Providers furnishing Emergency Services and care and any Post-Stabilization Care. This does not include Medi-Cal SMHS provided once an enrolled Member is admitted for inpatient psychiatric care. This is inclusive of voluntary or involuntary admission.

MCP Responsibility for Alcohol and Substance Use Disorder Screening, Referral, and Services

MCPs must provide or arrange for the for the provision of covered SUD services, which include:

- SABIRT Services: Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for Members ages 11 and older, including pregnant Members.
- Preventative Screenings: Tobacco, alcohol, and illicit drug screenings for adults and children, conducted in accordance with USPSTF grade A and B recommendations and AAP Bright Futures recommendations as outlined in APL 21-014.
- MAT Services: Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings
- Emergency and Post-Stabilization Services: All necessary services required to stabilize the MCP Member.[17]

MCPs must ensure that all contracted PCPs are authorized to issue referrals for covered SUD services. A Member is not required to seek a referral exclusively from their assigned PCP; any PCP participating in the Member's care may facilitate the referral process to prevent delays in treatment.

[16] See 22 California Code of Regulations (CCR) section 53855.

[17] Including voluntary inpatient detoxification as a benefit available to MCP Members through the Medi-Cal FFS program, as described in APL 18-001.

Care Management and Care Coordination

MCPs are required to cover care management for Medically Necessary Medi-Cal-covered physical health care services for Members receiving SMHS in accordance with the MCP Contract and the Population Health Management (PHM) Policy Guide or subsequent version of the Guide.[18] The MCP must ensure effective Care Coordination with the MHP. The MCP is responsible for the appropriate management of an MCP Member's mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all Medically Necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's Provider Network. For example, the MCP is required to ensure Transitional Care Services are provided for Members when discharged from an acute care facility per the requirements of the PHM Policy.

Mental Health Screening, Assessment, and Transitions of Care

At any time, MCP Members can choose to seek and obtain a mental health assessment from a licensed mental health Provider within the MCP's Provider Network. Each MCP is obligated to ensure that a mental health screening of MCP Members is conducted by a Network PCP. MCP Members with positive screening results may be further assessed either by the PCP or by referral to a Network mental health Provider. The MCP Member may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the MCP Member to a mental health Provider, first attempting to refer within the MCP's Network.

DHCS released a set of statewide Screening and Transition of Care tools, effective January 1, 2023, to facilitate transitions of care to specialty mental health treatment, Medi-Cal managed care, and FFS systems. Additional guidance is provided in APL 25-010, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services.

Effective April 1, 2026, DHCS will approve a list of youth trauma screening tools in Attachment A to identify if an MCP Member under the age of 21 has a condition placing them at high risk for a mental health disorder due to the experience of trauma, or needs further assessment, in alignment with BHIN 26-002. If a Provider determines that a youth trauma screening is necessary to identify eligibility for access to SMHS, only DHCS-approved tools listed in Attachment A may be used. Standard tool-specific

[18] The PHM Policy Guide can be found on the CalAIM PHM Initiative webpage at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

scoring methodology must be used to establish whether a Member scores in the "high-risk" range on a youth trauma screening tool approved by DHCS on Attachment A. In cases where there is no clear "high-risk" scoring range, MCPs must establish a process for determining whether the Member meets access criteria for SMHS.

If youth trauma is identified or screened for during a clinical assessment of a Member under the age of 21, clinical judgement may be used to determine the need for further assessment and/or to determine whether the Member meets access criteria for the SMHS delivery system.

Mental Health Parity

Treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.[19] MCPs must not require Prior Authorization for an initial mental health assessment.

DHCS recognizes that many PCPs provide initial Behavioral Health assessments, but not all do. If an MCP Member's PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services, either in the MCP's Provider Network or the County MHP's network in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and APL 22-005.

MCPs must ensure direct access to an initial mental health assessment by a licensed mental health Provider within the MCP's Provider Network. MCPs must not require a referral from a PCP or Prior Authorization for an initial mental health assessment performed by a mental health Network Provider. MCPs must notify Members of this policy, and the MCP's Member informing materials must clearly state that referral and Prior Authorization are not required for an MCP Member to seek an initial mental health assessment from a Network mental health Provider. MCPs are required to cover the cost of an initial mental health assessment completed by an Out-of-Network Provider only if there are no in-Network Providers that can complete the necessary service within the applicable timely and geographical access requirements set forth in APL 23-001.

If further services are needed that require authorization, MCPs are required to follow guidance developed for mental health parity, as set out below.

[21] See 42 Code of Federal Regulations (CFR) section 438(k).

MCPs must disclose the Utilization Management or Utilization Review policies and procedures (P&Ps) that they use to DHCS, their Network Providers, and any Subcontractors they use to authorize, modify, or deny health care services via Prior Authorization, concurrent authorization or retrospective authorization, under the benefits included in the MCP Contract.

MCPs' P&Ps must ensure that authorization determinations are based on the requested Medically Necessary health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such Utilization Management and Utilization Review P&Ps may also take into consideration the following:

- 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.
- Providers' adherence to quality and access standards.
- Other clinically relevant factors.

The P&Ps must be consistently applied to medical/surgical, mental health, and SUD benefits. The MCP must notify Network Providers of all services that require Prior Authorization, concurrent authorization or retrospective authorization and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for MCPs include making Utilization Management and Utilization Review criteria for Medical Necessity determinations for mental health and SUD benefits available to MCP Members, Potential Members, and Network Providers upon request in accordance with 42 CFR section 438.915(a). MCPs must also provide to Members the reason for any denial or partial denial for reimbursement or payment of services or any other Adverse Benefit Determination for mental health or SUD in accordance with 42 CFR section 438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.[20]

[20] Cultural and Linguistic Requirements can be found in 22 CCR section 53876.

MCP Responsibilities for Policies and Procedures, Subcontractors, and Enforcement Actions

MCPs must review their contractually required P&Ps to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, require a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal[21] within 90 calendar days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 calendar days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose enforcement actions, including corrective action plans, as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007. Any failure to meet the requirements of this APL may result in enforcement actions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Bambi Cisneros

Bambi Cisneros

Acting Division Chief, Managed Care Quality and Monitoring Division

Assistant Deputy Director, Health Care Delivery Systems

[21] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.