

State of California—Health and Human Services Agency  
Department of Health Care Services



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**DATE:** April 8, 2022

ALL PLAN LETTER 22-006  
SUPERSEDES ALL PLAN LETTER 17-018

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

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

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to explain the responsibilities of Medi-Cal managed care health 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). This APL also delineates MCP responsibilities for referring to, and coordinating with, County Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS). This APL supersedes APL 17-018.<sup>1</sup>

**BACKGROUND:**

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to address Medi-Cal beneficiaries' needs across the continuum of care, ensure that all beneficiaries receive coordinated services, and improve beneficiary health outcomes. DHCS' goal is to ensure that beneficiaries have access to the right care, in the right place, at the right time. CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including requirements regarding SMHS and NSMHS.<sup>2</sup>

Medical Necessity for SMHS

The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs.<sup>3</sup> For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections

<sup>1</sup> APLs are searchable at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

<sup>2</sup> For more information regarding CalAIM, please visit the CalAIM webpage at: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>.

<sup>3</sup> SHMS Waiver Information can be found at: [http://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)\\_Medi-cal\\_Specialty\\_Mental\\_Health\\_Waiver.aspx](http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx).

14059.5 and 14184.402, 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 Section 1396d(r)(5) of Title 42 of the United States Code (USC).<sup>4</sup>

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) 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.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition.<sup>5</sup> Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are 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, to prevent significant illness or significant disability, or to alleviate severe pain.<sup>6</sup>

County MHPs are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder, in accordance with SMHS access criteria described in Behavioral Health Information Notice (BHIN) No: 21-073.<sup>7</sup>

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<sup>4</sup> State law is searchable at: <https://leginfo.legislature.ca.gov/faces/codes.xhtml>.

See Section 1396d(r)(5) of Title 42 of the USC (requiring provision of all services that are coverable under Section 1905(a) of the Social Security Act (42 U.S.C. § 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/>.

<sup>5</sup> CMS’ federal EPSDT guidance can be found at:

[https://www.medicaid.gov/sites/default/files/2019-12/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf).

<sup>6</sup> W&I Code section 14059.5.

<sup>7</sup> 2021 BHINs are searchable at: <https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx>.

**POLICY:**

Medical Necessity for NSMHS

In accordance with W&I Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 42 of the USC.

The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that could be covered under a Medicaid State Plan (as described in 42 USC Section 1396d(a)) as needed 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.

Consistent with federal guidance from CMS, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

In accordance with W&I Code sections 14059.5 and 14184.402, 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.

MCP Responsibility for NSMHS<sup>8, 9, 10</sup>

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

1. Mental health evaluation and treatment, including individual, group and family psychotherapy.
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation.
5. Outpatient laboratory, drugs,<sup>11</sup> supplies, and supplements.

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<sup>8</sup> The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf>.

<sup>9</sup> W&I Code Section 14184.402

<sup>10</sup> More information regarding MCPs’ responsibility for alcohol and substance use disorder screening, referral, and services can be accessed in APL 21-014.

<sup>11</sup> This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: <https://medi-calrx.dhcs.ca.gov/home/cdl/>

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;<sup>12</sup>
- 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;<sup>13</sup> and,
- Members of any age with potential mental health disorders not yet diagnosed.

In addition to the above requirements, MCPs must provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder. MCPs are also required to cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal 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 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.<sup>14</sup>

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.

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<sup>12</sup> Presence of 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 recipient meets criteria to receive NSMHS. However, MCPs must provide or arrange for NSMHS for recipients with any of these or other co-occurring physical health or substance use disorders if they also have a mental health disorder (or potential mental health disorders not yet diagnosed) and meet criteria for NSMHS.

<sup>13</sup> See Section 1396d(r)(5) of Title 42 of the USC (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. The USC is searchable at: <https://uscode.house.gov/>.

<sup>14</sup> Medi-Cal Provider Manuals are searchable at: [https://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.aspx](https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx). The Medi-Cal Provider Manual, Non-Specialty Mental Health Services: Psychiatric and Psychological Services is available at <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf>

Consistent with state law, clinically appropriate and covered NSMHS are covered by MCPs even when:<sup>15</sup>

- 1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
- 2) Services are not included in an individual treatment plan;
- 3) The member has a co-occurring mental health condition and substance use disorder (SUD); or
- 4) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

More information regarding 1 to 4 and the No Wrong Door for Mental Health Services Policy can be found in APL 22-005.

At any time, 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 members is conducted by network Primary Care Providers (PCP). Members with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The 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 member to a mental health provider, first attempting to refer within the MCP network.

DHCS is developing a set of statewide tools (effective in 2023 pursuant to future guidance) to facilitate screenings and transitions care for the specialty mental health, Medi-Cal managed care, and fee for service systems. Future guidance regarding these tools will be provided through future updates to APL 22-005, No Wrong Door For Mental Health Services Policy.

MCPs must cover outpatient laboratory tests, drugs,<sup>16</sup> supplies, and supplements prescribed by mental health providers in the MCP's network and 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.

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<sup>15</sup> See W&I Code section 14184.402(f).

<sup>16</sup> This does not include medications covered under the Medi-Cal Rx Contract Drug List, which can be accessed at: <https://medi-calrx.dhcs.ca.gov/home/cdl/>

Consistent with APL 21-006<sup>17</sup> or subsequent guidance, 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 as described in Section 53855 of Title 22 of the California Code of Regulations (CCR).<sup>18</sup> This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

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

MCPs must provide covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, MCPs must provide or arrange for the provision of:

- Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.<sup>19</sup>

#### Care Management and Care Coordination

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an member receiving SMHS. The MCP must coordinate care with the MHP. The MCP is responsible for the appropriate management of a member's mental and physical health

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<sup>17</sup> Network Certification Requirement, APL 21-006:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006.pdf>

<sup>18</sup> The CCR is searchable at:

[https://govt.westlaw.com/calregs/index?\\_lrTS=20210423013246097&transitionType=Default&contextData=%28sc.Default%29](https://govt.westlaw.com/calregs/index?_lrTS=20210423013246097&transitionType=Default&contextData=%28sc.Default%29).

<sup>19</sup> Including voluntary inpatient detoxification as a benefit available to MCP members through the Medi-Cal fee-for-service program, as described in [APL 18-001](#).

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.

#### Mental Health Parity

Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) provides that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.<sup>20</sup> This precludes any restrictions to a member's access to an initial mental health assessment. Therefore, MCPs must not require prior authorization for an initial mental health assessment.

DHCS recognizes that while many PCPs provide initial behavioral health assessments but not all do. If a member's PCP cannot perform the mental health assessment, they must refer the member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in the MCP's provider network or the county mental health plan's network, is made in accordance with the No Wrong Door policies set forth in W&I Code 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 a 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 19-002 or subsequent guidance.

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

MCPs must disclose the utilization management or utilization review policies and procedures that they utilize 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.

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<sup>11</sup> See 42 CFR Subpart K – Parity in Mental Health and Substance Use Disorder Benefits: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-K>.

MCPs' policies and procedures (P&P) 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 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 criteria for medical necessity determinations for mental health and SUD benefits available to members, eligible beneficiaries, and network providers upon request in accordance with Title 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 Title 42, CFR, Section 438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.<sup>21</sup>

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCP) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCP contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

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<sup>21</sup> Cultural and Linguistic Requirements can be found in Title 22 CCR Section 53876.



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.<sup>22</sup> These requirements must be communicated by each MCP to all subcontractors and network providers. If you have any questions regarding this APL, please contact your MCO Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief  
Managed Care Quality and Monitoring Division

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<sup>22</sup> For more information on subcontractors and network providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.