

# **CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI) FEE SCHEDULE PROGRAM MANUAL**

**Guidance for Managed Care Plans and Insurers**

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## BACKGROUND AND PURPOSE

As part of Governor Newsom’s [Master Plan for Kids’ Mental Health](#) and the Children and Youth Behavioral Health Initiative (CYBHI), the Department of Health Care Services (DHCS) is expanding access to school-based (or school-linked) behavioral health services provided to students of public Transitional Kindergarten (TK)-12<sup>th</sup> grade local educational agencies (LEAs) and public institutions of higher education (IHEs) - specifically, the California Community Colleges (CCC), California State University (CSU) and University of California (UC) campuses (collectively referred to herein as “providers”). DHCS, in collaboration with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), established a statewide, multi-payer, school-linked fee schedule (CYBHI Fee Schedule) program to facilitate the reimbursement of school-linked providers for the provision of specified outpatient mental health and substance use disorder (SUD) services furnished to students 25 years of age or younger at a schoolsite.<sup>1</sup>

Commencing July 1, 2024,<sup>2</sup> Medi-Cal Fee-for-Service (FFS), Medi-Cal managed care plans (MCPs), commercial health care services plans, and disability insurers (collectively referred to herein as “MCPs and Insurers”) are obligated under state law<sup>3</sup> to reimburse eligible school-linked providers for the provision of CYBHI Fee Schedule covered services to plan enrollees and insured individuals.

DHCS contracted with a statewide third-party administrator (TPA) to support successful implementation of the CYBHI Fee Schedule with the goal of reducing administrative burdens on providers, MCPs and Insurers. In its role as the TPA, Carelon Behavioral Health (CBH)<sup>4</sup>, will serve as the single statewide entity responsible for operational

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<sup>1</sup> See Appendix A for a glossary of key terms.

<sup>2</sup> The statute requires MCPs and Insurers to reimburse school-linked providers for covered services beginning January 1, 2024; however, the statute also authorizes DHCS to implement the provisions only to the extent that DHCS obtains necessary federal approvals. As a result, DHCS determined it necessary to establish July 1, 2024, as the first date of service eligible for reimbursement under the CYBHI Fee Schedule program.

<sup>3</sup> [Welfare and Institutions Code § 5961.4](#); [California Health and Safety Code § 1374.722](#); [California Insurance Code § 10144.53](#)

<sup>4</sup> DHCS contracted (Agreement #23-30348) with CBH to serve as the state’s TPA. CBH was selected through a complete Request for Information (RFI) process. Since January 2024, CBH has been, in partnership with DHCS, administering the operational framework for the CYBHI Fee Schedule program.

administration of the CYBHI Fee Schedule program. CBH's responsibilities, at a high level, include:

- » **Oversight and management of the school-linked, behavioral health provider network** - This includes but is not limited to conducting screening and verification of school-linked providers' eligibility and qualifications (i.e., screening and credentialing); maintaining a roster of participating LEAs, IHEs and school-linked providers; establishing processes to monitor the network and provision of services, as well as to ensure program integrity and prevent fraud, waste and abuse; managing and implementing data-exchange frameworks to guide data exchange between providers and payers in compliance with state and federal requirements pertaining to data quality, privacy, confidentiality, and security.
- » Claims administration, claims adjudication and payment remittance for services rendered by school-linked providers as part of the CYBHI Fee Schedule program - This includes capabilities such as claims validation and adjudication, reconciliation and payment remittance, data management, and data quality and security.
- » Onboarding, implementation, and ongoing technical assistance services for participating LEAs, IHEs, designated providers and practitioners, and MCPs and Insurers - This includes but is not limited to providing support to LEAs, IHEs, school-linked providers, and MCPs and Insurers; serving as the designated point of contact program administration; collecting and reporting data; and committing to partnership with DHCS, and other partners identified by DHCS, to provide cohesive support to LEAs, IHEs, school-linked providers, and MCPs and Insurers.

Pursuant to DHCS' authority in the Welfare and Institutions Code § 5961(g), this guidance document outlines the policy and operational requirements for the CYBHI Fee Schedule program and details requirements for MCPs and Insurers, as well as the state's third-party administrator (TPA). To learn more about the CYBHI Fee Schedule, please visit DHCS' [CYBHI Fee Schedule program webpage](#) or contact DHCS at [DHCS.SBS@dhcs.ca.gov](mailto:DHCS.SBS@dhcs.ca.gov).

# OVERVIEW – CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE (CYBHI) FEE SCHEDULE PROGRAM

Studies find that more students will receive behavioral health services when they are provided at school.<sup>5</sup> The CYBHI aims to increase access to behavioral health services for children, youth, and families by expanding access to school-based behavioral health programs. The CYBHI Fee Schedule program<sup>6</sup> enables LEAs and IHEs to be reimbursed for behavioral health services without needing to negotiate directly with health insurance plans and disability insurers to establish network provider agreements. By establishing this sustainable funding mechanism for school-linked behavioral health services, the CYBHI Fee Schedule program aims to:

- » Increase access to school-linked behavioral health services for children and youth;
- » Ease administrative complexities for LEAs and IHEs by streamlining processes and requirements for reimbursement of covered school-linked behavioral health services furnished to students and alleviating LEA and IHE burdens related to negotiating contracts and rates with MCPs and Insurers;
- » Apply to multiple payers, easing uncertainty for school-linked providers identifying student’s coverage;
- » Expand the types of practitioners eligible for reimbursement for school-based behavioral health services to include Pupil Personnel Services (PPS) credentialed practitioners and Certified Wellness Coaches;<sup>7, 8</sup> and,

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<sup>5</sup> Refer to [The Landscape of School-Based Mental Health Services](#)

<sup>6</sup> [Introduction to the CYBHI Fee Schedule \(YouTube\)](#)

<sup>7</sup> Pending State Plan Amendment approval by the Centers for Medicare and Medicaid Services

<sup>8</sup> State Plan Amendment (SPA) 23-0027, approved by CMS on December 19, 2024, with an effective date of January 1, 2024, added Pupil Personnel Services (PPS) Credentialed School Counselors as eligible to render and bill for CYBHI Fee Schedule services. SPA 20-0014 was submitted to CMS on March 27, 2025, proposes to add Certified Wellness Coaches (CWC) services to the CYBHI Fee Schedule program, with a proposed effective date of January 1, 2025.

- » Provide state-funded supports for payers and providers, including contracting with the single statewide TPA to manage the provider network and facilitate claims administration/payment remittance.

## CYBHI Fee Schedule Program Covered Services

CYBHI Fee Schedule program covered services (CYBHI Covered Services) include medically necessary outpatient mental health and substance use disorder (SUD) services, including preventative, screening, assessment, and treatment services.<sup>9</sup> CYBHI Covered Services, including service descriptions, procedure codes, time increments, eligible practitioners, and rates are specified in the published fee schedule<sup>10</sup> on the [DHCS website](#).

Generally, CYBHI Covered Services are grouped into four categories:

1. **Psychoeducation Services:** Psychoeducation services involve providing individuals and their families with information and education about mental health conditions, SUDs, and related treatment options. Typically, this can include topics like understanding diagnoses, learning about medications and their side effects, and developing coping strategies. In school-settings, psychoeducation services may also be provided to students and their families for the purposes of identifying strategies and/or treatment options associated with a child's behavioral health needs with the goal of preventing or minimizing the negative effects of mental illness, emotional disturbances, substance abuse, or associated environmental stressors. This could include skill-building, such as mindfulness, de-escalation, and emotional regulation. Community Health Worker (CHW) Services and Certified Wellness Coach (CWC) Services are also covered.
2. **Screening and Assessment Services:** Screening and assessments can help identify students at risk for mental illness and/or substance use disorders, ensure that appropriate supports are provided to students across risk levels,<sup>11</sup> and

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<sup>9</sup> For the purposes of the Medi-Cal program, CYBHI covered services are Medi-Cal managed care and Medi-Cal FFS benefits, including the Non-Specialty Mental Health Services benefit; Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT); Community Health Worker Services; and (pending CMS approval) Certified Wellness Coach Services.

<sup>10</sup> [CYBHI Fee Schedule Scope of Services, Codes, and Reimbursement Rates](#)

<sup>11</sup> High risk = same day; Moderate risk = within the week; Low risk = communicate findings to staff, students, and parents within a reasonable time frame; Refer to [School Mental Health Quality Guide](#)

inform prevention and early intervention strategies. Information from screenings and assessments can be used by LEAs and IHEs to identify students who may need additional services and supports, including services covered by MCP and Insurers and delivered via network providers.

3. **Treatment Services:** Treatment services may include crisis intervention, individual, group or family counseling; and/or individual, group, or family psychotherapy.
4. **Care Coordination / Case Management:** Care coordination / case management services support and guide individuals and their families to community-based care options, social services support (e.g., Food Bank, housing), as well as support treatment planning and/or case-conferences with a Coordination of Services Team (COST), or another type of multidisciplinary treatment team.<sup>12</sup>

## Educationally Related Mental Health Services (Special Education Services)

LEAs and IHEs have existing obligations under state and federal law to provide or arrange for the provision of services rendered pursuant to an Individualized Education Plan (IEP), an Individualized Family Services Plan (IFSP), or a 504 plan, including all services for which the LEA receives state or federal funding. The Individuals with Disabilities Act (IDEA) requires LEAs to provide Free Appropriate Public Education (FAPE) for students with disabilities and creates a legal obligation for LEAs/IHEs to ensure services included on a student's IEP or IFSP are provided to the student.<sup>13</sup> The CYBHI statutes specify that the CYBHI Fee Schedule program does not "relieve [an LEA or IHE] from requirements to accommodate or provide services to students with disabilities pursuant to any state and federal law."<sup>14</sup> This exclusion in CYBHI does not mean that LEAs and IHE, or their designated providers, may not seek reimbursement for CYBHI covered services provided to any student with a disability. Instead, DHCS operationalizes this requirement to mean the following:

- » LEAs/IHEs and designated providers **may not seek** reimbursement for services rendered pursuant to an IEP or IFSP. Specifically, this means that services that

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<sup>12</sup> MCP Members receiving SMHS Targeted Case Management (TCM) from counties can also be eligible for and receive Enhanced Care Management (ECM) services in school-linked settings. MCPs are required to work with counties to identify Members receiving SMHS TCM and ensure non-duplication of services (see [ECM policy guide](#))

<sup>13</sup> Individuals with Disabilities Education Act (IDEA) <https://sites.ed.gov/idea/statuteregulations/>Part B. Assistance for All Children with Disabilities

<sup>14</sup> Welfare and Institutions Code § 5961.4(i)

are specified in a student's IEP or IFSP are not eligible for reimbursement as part of the CYBHI Fee Schedule program.

- » LEAs and IHEs **may seek** reimbursement for medically necessary CYBHI covered services furnished to a student with an identified disability, so long as the specific services claimed for reimbursement were not specified in the student's IEP or IFSP.<sup>15</sup>
- » LEAs/IHEs and designated providers **may seek** reimbursement for **initial** IEP assessments (specifically related to a mental health or substance use disorder condition or symptoms), including screenings and psychological testing utilized to inform initial disability determination under the IDEA, for students that did not previously have an IEP or IFSP. If it is determined the student meets disability criteria and an IEP and/or IFSP is established, subsequent reassessments would not be eligible for reimbursement.<sup>16</sup>

## Medically Necessary Treatment

Under the CYBHI statutory authority, MCPs and Insurers are mandated to reimburse school-linked providers for the provision of **medically necessary** CYBHI covered services to a student under the age of 26.<sup>17,18</sup>

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<sup>15</sup> Illustrative example: a student has an IEP related to anxiety disorder symptoms that adversely affect the student's academic progress. Pursuant to the IEP, the student will receive individual counseling services one time per week. However, during the school year, the student's beloved pet dies, and the student experiences subsequent feelings of grief, sadness and loneliness. The PPS-credentialed school counselor invites the student to a weekly group counseling session focused on grief and loss. In this example, the weekly individual counseling services are not eligible for reimbursement, but the weekly group counseling sessions are eligible for reimbursement under the CYBHI Fee Schedule program.

<sup>16</sup> The CYBHI Fee Schedule program only provides reimbursement for outpatient behavioral health (mental health and substance use disorder) services. Initial IEP assessments for students with cognitive disorders, intellectual disabilities, physical health conditions, or other non-behavioral health (i.e., mental health and substance use disorder) conditions or symptoms are not reimbursable under the CYBHI Fee Schedule program.

<sup>17</sup> [Welfare and Institutions Code § 5961.4](#); [California Health and Safety Code § 1374.722](#); [California Insurance Code § 10144.53](#)

<sup>18</sup> See exceptions pertaining to individuals enrolled in a Health Savings Account qualified High-Deductible Health Plan, page 12.

## Defining medical necessity

The Mental Health Parity and Addiction Equity Act (MHPAEA) federally mandates parity in the treatment of behavioral health and medical/surgical benefits by group health plans or health insurance issuers (including for individual health insurance coverage) across all ages.<sup>19,20</sup>

For commercial health care services plans and disability insurers, the California Health and Safety Code section 1374.72(a)(3)(A) and the California Insurance Code section 10144.5(a)(3)(A) specify that “medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient, **for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression....**”

For Medi-Cal students who are under the age of 21, a service is “medically necessary” if it is provided to correct or ameliorate health defects, physical and mental illnesses, and conditions discovered by screening services, whether or not such services are covered under the State Plan.<sup>21,22</sup> Services that maintain or improve a child’s current health condition are covered because they “ameliorate” a condition. Services are covered when they prevent a condition from worsening and/or prevent the development of additional health problems.

For Medi-Cal students who are 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.<sup>23</sup>

## Determining medical necessity

Eligible rendering practitioners, within their scope of practice, will determine if a service provided to a student is medically necessary. School-linked providers’ determination whether a service is medically necessary must:<sup>24</sup>

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<sup>19</sup> [CMS. The Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#)

<sup>20</sup> [DHCS’s All Plan Letter 22-006](#) (or superseding guidance, as applicable) explains the responsibilities of Medi-Cal 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).

<sup>21</sup> [DHCS Medi-Cal for Kids and Teens Provider Information website](#)

<sup>22</sup> [42 U.S.C. §1396d\(r\)\(5\)](#)<sup>23</sup> [Welfare and Institution Code § 14059.5\(a\)](#)

<sup>23</sup> [Welfare and Institution Code § 14059.5\(a\)](#)

<sup>24</sup> [DHCS Medi-Cal for Kids & Teens Provider Information – Medical Necessity](#)

1. Take into account the particular needs of the child
2. Be made on a case-by-case basis

School-linked providers are not required to submit documentation demonstrating medical necessity (i.e., assessments and treatment plans are not required to demonstrate that services were medically necessary) to substantiate a claim for reimbursement.

## Prior Authorization and Reasons for Denial of Claims

MCPs and Insurers shall not require prior authorization for CYBHI covered services furnished to an individual 25 years or younger, who is an enrollee of the MCP and Insurer, at a schoolsite.<sup>25</sup> The CYBHI statutes permit MCPs and Insurers to conduct a post-claim review to determine appropriate payment of a CYBHI Fee Schedule program claim; however, payment may be denied only if the MCP or Insurer reasonably determines that the services were provided to a student not covered by the MCP or Insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.<sup>26</sup> The statute does not permit MCPs and Insurers to deny a claim because the MCP or Insurer determines, as part of a post-claim review, the service was not medically necessary.<sup>27</sup>

## CYBHI Fee Schedule Provider Network

State law requires DHCS to develop and maintain a statewide network of school-based and school-linked providers.<sup>28</sup> As such, to be eligible for reimbursement under the CYBHI statutes, eligible entities must either: 1) apply to DHCS to participate in the statewide network of school-linked behavioral health providers; 2) have direct contracts with MCPs and Insurers;<sup>29</sup> or, 3) be designated by an eligible entity. Provider entities eligible to apply directly with DHCS include:

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<sup>25</sup> [Health and Safety Code § 1374.722\(c\)\(1\)](#); [Insurance Code § 10144.53\(c\)\(1\)](#)

<sup>26</sup> [Health and Safety Code § 1374.722\(c\)\(2\)](#); [Insurance Code § 10144.53\(c\)\(2\)](#)

<sup>27</sup> For additional information, see [DMHC APL 23-026](#) and [CDI guidance AB 133](#)

<sup>28</sup> [Welfare and Institutions Code § 5961.4\(b\)](#)

<sup>29</sup> LEAs, IHEs, and designated providers / practitioners are **not** required to have direct contracts with MCPs or insurers to be reimbursed, at published rates, for CYBHI covered services and MCPs and Insurers must provide reimbursement regardless of provider network status. [Welfare and Institutions Code § 5961.4\(c\)](#); [Health and Safety Code § 1374.722\(a\)\(1\)](#); [Insurance Code § 10144.53\(a\)\(1\)](#)

- » LEAs, including county offices of education (COEs), school districts, charter schools, California Schools for the Deaf, and the California School for the Blind; and,
- » Public institutions of higher education (IHEs), including California Community Colleges, California State Universities, University of California campuses.

**The LEA or IHE is the central figure in the CYBHI Fee Schedule program.** However, as part of the CYBHI statutes,<sup>30</sup> the California Health and Safety Code § 1374.722(b)(6) and Insurance Code § 10144.53(b)(6) define a ‘schoolsite’ to mean a location where a “public school or public school district... provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.”<sup>31</sup> DHCS operationalizes this to mean LEAs and IHEs may designate community-based school-linked providers and practitioners as eligible entities able to receive reimbursement as part of the CYBHI Fee Schedule program. For a community-based school-linked provider to be eligible to participate, LEAs and/or IHEs **must** designate that the community-based provider is part of their ‘network of designated providers and practitioners’ serving enrolled students of the district, college or university. Therefore, in alignment with the statute, services of a designated provider are furnished at a location where the LEA or IHE “arranges for the provision” of medically necessary mental health or substance use disorder services (behavioral health services). The LEA’s or IHE’s designated provider and practitioner network may include:

- » **Practitioners directly employed** by an LEA or IHE, including Pupil Personnel Services (PPS) credentialed practitioners, licensed behavioral health practitioners, Certified Wellness Coaches<sup>32</sup>, Community Health Workers<sup>33</sup> and other qualified professionals eligible to furnish medically necessary services under the CYBHI Fee Schedule program,

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<sup>30</sup> [Welfare and Institutions Code § 5961.4](#); [Health and Safety Code § 1374.722](#); [Insurance Code § 10144.53](#)

<sup>31</sup> Services covered under the CYBHI Fee Schedule may be billed by participating LEAs, IHEs, and/or their designated providers and practitioners, as applicable, when delivered in-person during face-to-face visits or via telehealth, in accordance with [DHCS’ telehealth policy](#).

Telehealth services are reimbursable if the practitioner believes that the service being provided is clinically appropriate based upon evidence-based medicine or best practices or both.

<sup>32</sup> For Medi-Cal reimbursement (only), pending approval of [State Plan Amendment 25-0014](#)

<sup>33</sup> Refer to [All Plan Letter 22-016](#)

- » **Embedded providers or practitioners** – including but not limited to community-based providers, clinics, or individual licensed behavioral health practitioners that are **contracted** to provide medically necessary services **on behalf of** the LEA or IHE; and/or,
- » **Affiliated providers or practitioners** – including but not limited to community-based providers, clinics, counties, or individually licensed behavioral health practitioners to which the LEA or IHE **refers students for services but does not have a formal agreement** or financial relationship.

To be eligible for reimbursement of covered services under the CYBHI Fee Schedule program, community-based providers must be either employed by, contracted by or affiliated with a participating LEA or IHE **and** designated by the LEA or IHE.<sup>34</sup> An LEA/IHE can designate a community-based provider by including them on the [Standard Provider Import \(SPI\)](#) roster file submitted to CBH or—for select “statewide” affiliated providers—by providing the affiliated provider with an Affiliated Provider Designation and Acknowledgement Letter. Further, as a condition of participation, designated *affiliated* community-based providers and practitioners must be actively enrolled in the Medi-Cal program via DHCS’ Provider Application and Validation for Enrollment (PAVE) system. For additional information, see [Guidance for the Participation of Community Providers](#).

The CYBHI Fee Schedule program is intended to reimburse schools, school districts (i.e., school-based providers) and their community partners (i.e., school-linked providers) that furnish outpatient behavioral health services to students under the age of 26. While state law provides DHCS authority to allow community-based **school-linked** providers and practitioners to participate in the CYBHI Fee Schedule program, the statute does not intend to circumvent existing MCPs’ and Insurers’ network contracting authorities. Only “designated” community providers may be reimbursed for services furnished to students covered by an MCP or Insurer who are enrolled in the LEA or IHE that designated the community-based provider. Without a formal designation by an LEA or IHE, community-based providers are not eligible for reimbursement under the CYBHI Fee Schedule program.

## Eligible Designated Practitioner Types

LEAs, public institutions of higher education, or designated providers may embed (e.g., employ or contract with) or affiliate with individual practitioners to render services to a

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<sup>34</sup> For additional information, see [CYBHI Fee Schedule program Guidance for the Participation of Community Providers](#)

student in accordance with scope of practice requirements in state law. Eligible individual practitioners vary by service code and include the following:<sup>35</sup>

*Licensed practitioners:*

- » Physicians, including DOs and Psychiatrists
- » Licensed Psychologists
- » Licensed Educational Psychologists
- » Licensed Clinical Social Workers
- » Licensed Marriage and Family Therapists
- » Licensed Professional Clinical Counselors
- » Licensed Nurses (e.g., Nurse Practitioners, Registered Nurses, Registered Credentialed School Nurses, Licensed Vocational Nurse)
- » Physician Assistants

*Non-licensed practitioners:*

- » Alcohol and Other Drug (AOD) Counselors<sup>36</sup>
- » Community Health Workers<sup>37</sup>
- » Registered Associate Marriage and Family Therapists
- » Registered Associate Social Workers
- » Registered Associate Professional Clinical Counselors
- » Registered Psychology Associates
- » Clinical Trainees<sup>38</sup>
- » PPS Credentialed School Counselor
- » PPS Credentialed School Psychologist
- » PPS Credentialed School Social Worker

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<sup>35</sup> See the [published](#) CYBHI Fee Schedule for details

<sup>36</sup> Refer to [AOD counselors certified by a National Commission for Certifying Agencies accredited organization](#)

<sup>37</sup> Refer to [All Plan Letter 22-016](#)

<sup>38</sup> Pending approval of [SPA 25-0038](#)

- » Certified Wellness Coaches<sup>39</sup>

## Reimbursement Rates and Cost-Sharing Prohibitions

MCPs and Insurers must reimburse LEAs, IHEs, and their designated providers, for the provision of CYBHI covered services to a student, who is an enrollee of the MCP or Insurer, when services are delivered at a schoolsite. An MCPs or Insurer must provide reimbursement at the greater of the following amounts:

- » The fee-for-service reimbursement rate published by DHCS pursuant to Welfare and Institutions Code Section 5961.4(a); or,
- » The MCP or Insurer's contracted rate with an LEA, IHE or designated provider. NOTE: The state's TPA will only reimburse eligible providers at the rates published in DHCS' fee schedule. MCPs and Insurers will reimburse LEAs, IHEs, or designated providers at contracted rates only when claims for reimbursement are submitted directly to the MCP or Insurer for payment.

This requirement applies to MCPs and Insurers even when the MCP or Insurer has a direct contract with an LEA, IHE or designated provider participating in the CYBHI Fee Schedule program.

## Cost-Sharing Prohibitions

CYBHI covered services shall not be subject to cost-sharing, including co-payment, coinsurance, deductible or any other form of cost-sharing.<sup>40</sup> Neither an MCP, Insurer, LEA, IHE nor designated provider may bill the enrollee or subscriber (i.e., the student or their parent/guardian) nor seek reimbursement from the enrollee or subscriber (i.e., the student or their parent/guardian) for the provision of CYBHI covered services.

## HSA-Qualified High-Deductible Health Plans

Distinct from the cost-sharing mechanisms described above, High-deductible health plans (HDHPs) that qualify for Health Savings Accounts (HSAs) under section 223 of the Internal Revenue Code (IRC) may not provide benefits for non-preventive-care services until the applicable deductible(s) are met. The application of Section 1374.722 and Insurance Code Section 10144.53 shall not disqualify or otherwise disrupt an HDHP from meeting the requirements of the Internal Revenue Code or its implementing rules as they relate to HSA eligibility. Therefore, in order to harmonize Health and Safety Code Section 1374.722 and Insurance Code Section 10144.53 with federal rules regarding

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<sup>39</sup> For Medi-Cal reimbursement (only), pending approval of [State Plan Amendment 25-0014](#)

<sup>40</sup> [Health and Safety Code § 1374.722\(c\)\(7\) and \(8\); Insurance Code § 10144.53\(c\)\(7\) and \(8\)](#)

HDHPs and HSAs, the state clarifies that, for enrollees of HDHPs otherwise qualifying under section 223 of the Internal Revenue Code, health care service plans shall not reimburse for services covered under Health and Safety Code Section 1374.722 and Insurance Code Section 10144.53 unless (a) the applicable IRC deductible has been met, or (b) the service is for preventive care, as that term is used by the federal government for purposes of implementing section 223 of the Internal Revenue Code.

DHCS encourages MCPs and Insurers to define preventative services eligible for reimbursement regardless of the member's deductible status.

### **Medi-Cal Share of Cost**

Some Medi-Cal beneficiaries may still be required to pay a monthly dollar amount for the Share of Cost (SOC) prior to qualifying for Medi-Cal benefits. This may be determined through the Automated Eligibility Verification System (AEVS). If AEVS indicates a beneficiary has a SOC, the SOC must be met before a beneficiary is eligible for benefits. The SOC amount is determined by the county welfare department and is administered by Medi-Cal.

## **MCP, INSURER AND THIRD-PARTY ADMINISTRATOR (TPA) ROLES AND RESPONSIBILITIES**

State law authorizes DHCS to contract with an entity to administer the school-linked statewide behavioral health provider network, administer claims and payment remittance, and support LEAs, IHEs, designated providers and practitioners, and MCPs/insurers.<sup>41</sup> MCPs and Insurers must delegate certain functions to the state's TPA, Carelon Behavioral Health (CBH),<sup>42</sup> which will serve as the single statewide entity responsible for operational administration of the CYBHI Fee Schedule program. In this role, CBH will perform the following delegated functions:

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<sup>41</sup> [Welfare and Institutions Code § 5961.4\(d\)](#)

<sup>42</sup> DHCS contracted (Agreement #23-30348) with CBH to serve as the state's TPA. CBH was selected through a complete Request for Information (RFI) process. Since January 2024, CBH has been, in partnership with DHCS, administering the operational framework for the CYBHI Fee Schedule program. See Appendix B for CBH's Scope of Work pursuant to its contract with DHCS.

- » Create and administer a process for enrolling and screening all eligible practitioners and providers seeking to provide medically necessary schoolsite services described;
- » Create and administer a process for the submission and reimbursement of claims eligible to be reimbursed as part of the CYBHI Fee Schedule program;
- » Resolve disputes related to the CYBHI Fee Schedule program;
- » Create and administer a mechanism for the sharing of data between the TPA and MCPs and Insurers, that is necessary to facilitate timely claims processing, payment, and reporting; avoid duplication of claims; allow for tracking of grievance remediation; and facilitate coordination of care and continuity of care for MCP or Insurer enrollees;<sup>43</sup>and,
- » Other functions specified by DHCS. *Additional details to follow.*

MCPs and Insurers that cover medically necessary CYBHI covered services must comply with all administrative requirements necessary to cover and reimburse those services set forth by DHCS and/or the state’s TPA.<sup>44</sup> To the extent that an MCP or Insurer has a direct contract with an LEA, IHE, or designated provider of an LEA or IHE, the MCP or Insurer must comply with all administrative requirements necessary to cover and reimburse medically necessary schoolsite services subject to the CYBHI statutes.<sup>45</sup> This means that an MCP or Insurer that contracts directly with an LEA or IHE must comply with the CYBHI Fee Schedule program guidance and policies herein. Further, unless the MCP or Insurer has a direct contract with **all LEAs and IHEs** in the MCP or Insurer’s service area, the MCP or Insurer must enter into all necessary agreements with the state’s TPA, utilize DHCS-approved forms/templates, and streamline the provision and reimbursement of school-based behavioral health services in accordance with this guidance.

## **Provider Network Oversight Functions**

Upon approval by DHCS of an LEA, IHE, or designated statewide affiliated provider<sup>46</sup>, to participate in the CYBHI Fee Schedule program, CBH is responsible for carrying out all applicable provider network oversight functions for all participating providers (CYBHI

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<sup>43</sup> [Welfare and Institutions Code § 5961.4\(d\)\(2\)](#)

<sup>44</sup> [Welfare and Institutions Code § 5961.4\(f\)\(1\)](#)

<sup>45</sup> [Welfare and Institutions Code § 5961.4\(f\)\(2\)](#)

<sup>46</sup> For additional information, see CYBHI Fee Schedule program [Participation of Community Providers guidance](#)

Providers). MCPs and Insurers must delegate these functions, as it relates specifically to the CYBHI Fee Schedule program, to CBH for all CYBHI Providers.

LEAs and IHEs, and/or their designated statewide affiliated providers, will submit to CBH a detailed Standard Provider Information (SPI) roster file that includes all organizational, group and individual providers participating in the CYBHI Fee Schedule program. All CYBHI Providers are required to obtain a National Provider Identifier, Type I or Type II, as applicable. CBH will conduct state and federally mandated screening (and re-screening, as required) of all CYBHI providers utilizing DHCS-approved procedures.<sup>47</sup> CBH will provide DHCS with a roster of all active providers in the network and DHCS, in turn, will make the roster available to MCPs and Insurers.

CBH will also carry out quality reviews and oversight responsibilities, including conducting ongoing quality monitoring and oversight activities for each participating LEA, IHE, and designated provider. CBH will monitor the network of designated providers/practitioners, including performance monitoring and upholding of quality standards that are consistent with broader Medi-Cal, commercial health plans, and disability insurers' requirements and any additional quality standards as outlined by DHCS as part of the CYBHI. See Appendix B for additional details about CBH's scope of work under its contract with DHCS.

## **Claims Payment and Member Eligibility Verification - Delegation Models**

Each MCP and Insurer must delegate<sup>48</sup> certain claims adjudication, member eligibility verification, and payment functions to be solely performed by CBH in its capacity as the single statewide entity responsible for operational administration of the CYBHI Fee Schedule program.

To effectuate its role as the single statewide entity, CBH will automate workflows, which requires systems integration with MCPs and Insurers. This automation will be implemented in two distinct phases:

1. Interim Clean Claims Payment Model (Interim Model)
2. Administrative Services Organization Payment Model (ASO Model)

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<sup>47</sup> See [CBH's CYBHI TPA Screening Process](#)

<sup>48</sup> In the context of the CYBHI Fee Schedule program, this 'delegation' is required as part of the program implementation and such delegation originates from DHCS' contract with CBH. Each MCP/Insurer will enter into MOUs, which outline specific roles and responsibilities as a part of these models.

Unless an MCP or Insurer has an existing ASO Model relationship with CBH, each MCP and Insurer must execute an Interim Model Memorandum of Understanding (MOU) with CBH. During the Interim Model phase, CBH and the MCP or Insurer will jointly carry out eligibility and payment functions, as described in the Interim Model MOU and Interim Model Workflow.<sup>49</sup> Each MCP and Insurer must work collaboratively with CBH to implement both the Interim Model and the ASO Model infrastructure during the Interim Model phase, as directed by DHCS. Upon full implementation of the ASO Model, which includes the execution of an ASO Model MOU, the Interim Model MOU will no longer be in effect. During the ASO Model phase, the MCP or Insurer will delegate eligibility and payment functions solely to CBH.

**IMPORTANT NOTE: MCPs and Insurers are obligated under state law to provide reimbursement for claims paid by CBH regardless of the status of implementation of either the Interim Model or the ASO Model. MCPs and Insurers must make timely payments of invoices for paid claims in accordance with relevant state laws.**

This section details the roles and responsibilities of MCPs and Insurers and CBH for each phase and implementation model.

## Interim Model

During the Interim Model period (i.e., July 1, 2024 – Date of Executed ASO Model MOU), CBH will act as a claims clearinghouse for all enrolled and participating LEAs, IHEs, and designated affiliated providers. All CYBHI Fee Schedule program claims must be submitted to CBH for adjudication and payment. Upon receipt, CBH will adjudicate the claims to determine if the claim meets the “clean claim” requirements in state law.<sup>50,51</sup> If the claim does not meet the “clean claim” requirements, CBH will deny the claim and return the claim unpaid to the billing entity. CBH will then work with the LEA, IHE or designated affiliated provider to make necessary corrections and resubmit the claim for payment.

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<sup>49</sup> [Interim Model MOU; Interim Model Workflow](#)

<sup>50</sup> Per Title 42 of the Code of Federal Regulations (CFR), Section 447.45(b), a “clean claim” is defined as, “one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.” Refer to [42 CFR Part 447 Subpart A](#).

<sup>51</sup> For commercial plans and insurers, the claim must meet the requirements of a “complete claim” as specified in the California Code of Regulations, Title 28, § 1300.71(2)(D)

Once CBH adjudicates the claim and determines the “clean claim” is eligible for payment, CBH will pay the claim within state mandated timeframes for timely payments (see below). CBH will draw funds to initially pay claims from DHCS’ Interim Claim and Bad Debt Pool.

However, MCPs and Insurers are responsible for coverage and payment of all “clean claims” submitted as part of the CYBHI statutes and all funds initially paid from DHCS’ Interim Claims and Bad Debt Pool **must be timely repaid by the MCPs and Insurers**, as applicable, to CBH to reimburse the fund. Ultimately, these funds will be returned to DHCS.

To effectuate timely payment of claims by MCPs and Insurers, CBH will invoice the applicable MCP or Insurer for “clean claims” paid to LEAs, IHEs, and designated affiliated providers. Using the DHCS-approved template, CBH will transmit the invoice to the MCP or Insurer electronically. MCPs and Insurers may choose to either 1) build the system infrastructure to ingest the invoice into the MCP or Insurer’s payment (or other) system; or, 2) pay the invoice manually without ingesting the invoice into the MCP or Insurer’s payment (or other) system.

MCPs and Insurers will review all claim lines included on the invoice to verify the member (student/family member) is enrolled in the MCP or Insurer and was eligible to receive services on the date the services were furnished to the member. Unless the MCP or Insurer determines that a member was not covered on the date of service, or otherwise ineligible for the services, the MCP or Insurer must pay the invoice within twenty-one (21) calendar days of receipt.

If the MCP or Insurer determines that a member was not covered/eligible to receive services on the date of service, the MCP or Insurer may reject specific claim lines on the invoice and reduce the reimbursement amount paid to CBH. This will be considered an overpayment and CBH will take appropriate actions to recover the overpayment from the billing provider.

During the Interim Model period, CBH **will not** transmit a Standard 837 Transaction with encounter data to the MCP or Insurer.<sup>52</sup> Within sixty (60) business days of completing ASO Model implementation, CBH will send the MCP or Insurer a complete encounter data record for all Clean Claims paid during the Interim Model period.

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<sup>52</sup> DHCS acknowledges that MCPs/Insurers will be delayed due to their inability to comply with state and federal requirements related to CYBHI Fee Schedule program encounter data. MCPs and Insurers must report encounters upon receipt of the Standard 837 Transaction file from CBH.

For specific Interim Model workflow details, see Appendix C, CBH’s Interim Model MOU and Companion Guide.

## **ASO Model**

Under the ASO Model for the CYBHI Fee Schedule program, all MCPs and Insurers will fully delegate member/insured enrollment verification and claims adjudication functions to CBH. MCPs and Insurers must execute ASO Model MOU agreements with CBH.<sup>53</sup> ASO Model implementation will be phased based on CBH capacity.<sup>54</sup> DHCS will select and prioritize MCPs and Insurers for ASO onboarding with the aim of completing all ASO onboarding by August 2027.<sup>55</sup> MCPs and Insurers must collaborate with CBH to establish necessary systems infrastructure for ASO Model implementation. See Appendix D for CBH’s ASO Implementation Timeline and Systems Discovery Worksheet.

As part of implementing the ASO Model workflows for member eligibility verification, MCPs and Insurers must transmit their member enrollment data to CBH, at a frequency mutually agreed upon and established with CBH during the ASO Model implementation phase.

## **Payment Timelines**

CYBHI Providers must submit claims to CBH no later than 365 days after the date of service to be eligible for reimbursement.<sup>56</sup>

Once claims are submitted to CBH, CBH will review and adjudicate the claims. CBH will issue payments to the billing entity on an approved claim. Timelines for payment remittance begin once CBH has received the claim.

CBH’s payment timelines, as determined by the appropriate regulating entity, are detailed below (see Table 1):

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<sup>53</sup> The ASO Model MOU has not yet been finalized. DHCS continues to work collaboratively with MCPs and Insurers and CBH to finalize the terms of this agreement.

<sup>54</sup> See Appendix D

<sup>55</sup> Timeline subject to change

<sup>56</sup> Welfare and Institutions Code § 5961.4(d)(2)(C)(iii)(II); Statutes of 2025, Chapter 105, Section 49 (AB 144)

**Table 1: Timely payment requirements**

MCP or Insurer type	Timely payment requirement	Source
Medi-Cal MCPs	No later than 30 calendar days after claim receipt by CBH for 90% of all clean claims In addition, 99% of all clean claims shall be paid within ninety (90) days of receipt	DHCS <a href="#">APL 23-020</a>
Commercial full service health plans <sup>57</sup>	No later than 30 calendar days after claim receipt by CBH	<a href="#">CA Health and Safety Code section 1371</a>
Disability insurance	No later than 30 calendar days after claim receipt by CBH	<a href="#">California Insurance Code section 10123.13</a> <a href="#">California Insurance Code section 10123.147</a>

## Claims Adjudication, Denials and Recoupments

CBH is responsible for adjudicating claims to verify the claim is complete and includes all required fields and data elements for the claim, as indicated on the standard CMS-1500 format (or electronic HIPAA-compliant 837 transaction).<sup>58</sup>

CBH will conduct a post-claim review to determine appropriate payment of a CYBHI Fee Schedule program claim; however, payment may be denied only if CBH reasonably determines that the services were provided to a student not covered by the MCP or Insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.<sup>59</sup> The statute does not permit MCPs and Insurers to deny a claim because the MCP or Insurer determines, as part of a post-claim review, the service was not medically necessary.<sup>60</sup>

Claims that are denied because of clean claim errors (e.g., claim is missing the rendering provider’s NPI), provider eligibility (i.e., the provider was not listed on the LEA, IHE or designated affiliated provider’s SPI roster), or student eligibility errors (i.e., inaccurate

<sup>57</sup> State law is changing in 2026 to revise this requirement to 30 calendar days per AB 3275. See [DMHC’s guidance](#)

<sup>58</sup> <https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1500.pdf>

<sup>59</sup> [Health and Safety Code § 1374.722\(c\)\(2\); Insurance Code § 10144.53\(c\)\(2\)](#)

<sup>60</sup> For additional information, see [DMHC APL 23-026](#) and [CDI guidance AB 133](#)

student health insurance information was furnished to CBH) may be corrected and resubmitted to CBH for payment.

Although the CYBHI statutes limit the reasons that a claim may be denied, CYBHI Fee Schedule claims may be subject to a post-payment audit to verify the claim's validity. Either CBH, the MCP or Insurer, and/or DHCS may conduct a post-payment audit of LEA, IHE or designated community-based school-linked provider records and claims. LEAs, IHEs and designated community-based school-linked providers must retain CYBHI Fee Schedule program documentation for a period of ten (10) years in accordance with federal Medicaid requirements.<sup>61</sup>

Overpayments may occur if a claim is initially paid by CBH but subsequently there is a determination that the claim was not eligible for payment (see reasons for denials above). When an overpayment occurs, the billing provider is responsible for returning the payment.

Overpayments may result from any of the following:

- » Claims paid in error.
- » Claims allowed or paid greater than billed.
- » Duplicate payments.
- » Payments made for individuals (i.e., students or family members of students) whose benefit coverage is or was terminated.
- » Payments made for behavioral health services in excess of applicable benefit limitations.
- » Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines.
- » Fraud, waste or abuse.
- » As a result of a post-payment audit, it is later determined to be ineligible for payment.

CBH will recover overpayments by either:

- » Creating of a negative balance for the CYBHI Provider. Future claims payments may then be offset by the amount of the overpayment; or,

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<sup>61</sup> 42 C.F.R. § 438.3(h)

- » Notifying the CYBHI Provider, in writing, of the overpayment and requests repayment.

## Duplicate claims

CYBHI Providers are responsible for ensuring duplicate claims are not submitted for payment. CYBHI Providers may not duplicate claims for the same student with the same date of service and procedure codes, including as follows:

1. Within the CYBHI Fee Schedule program (i.e., same claim submitted multiple times to CBH);
2. Between the CYBHI Fee Schedule program and any direct contracts with MCPs and Insurers; and
3. Between the CYBHI Fee Schedule program and other state- or federally funded programs (e.g., the Local Educational Agency Medi-Cal Billing Option Program).

If a CYBHI provider submits an identical claim for payment to both CBH and the MCP or Insurer, CBH is the primary delegated payer in all such instances. The MCP or Insurer must either deny the claim or, if identified as part of a post-payment audit, issue an overpayment and recoup the funds, if applicable.

Duplicate claims are not permitted and will be denied.<sup>62</sup> Both CBH and MCPs or Insurers may identify and deny duplicate claims as they are reviewed or upon subsequent audits. CYBHI Providers that erroneously receive payment for duplicate claims (i.e., overpayment) may be required to return duplicate payments to the respective program, MCP, or Insurer, as applicable.

## Other Administrative Functions

### Member Grievances and Appeals

CBH is delegated for handling all member grievances and appeals pertaining to CBH's scope of work pursuant to its contract with DHCS. This includes, but is not limited to:

- » Receiving grievances and appeals from members regarding covered services.
- » Investigating and resolving grievances and appeals in a timely manner as specified by applicable regulations.

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<sup>62</sup> [DHCS remittance advice details code 010: Denials for Duplicate Claims](#)

- » Documenting and maintaining records of all grievances and appeals and the resolutions provided.

CBH will develop and make available to LEAs and IHEs a single CYBHI Fee Schedule program member grievance form for use by members receiving services at a school-linked schoolsite.

When a grievance is received by CBH from a CYBHI Provider, CBH will promptly acknowledge its receipt, providing the member<sup>63</sup> and the submitting entity with a reference number, a summary of the issue, and an estimated timeline for resolution. CBH will conduct a comprehensive review and investigation of the grievance related to covered services rendered as part of the CYBHI Fee Schedule program. This activity involves gathering necessary information and consulting with experts as needed to understand the issues thoroughly.

CBH will complete the investigation within state-regulated timeframes in accordance with state laws and regulations. See table below:

**Table 2: Grievance resolution timeframes requirements**

MCP or Insurer type	Grievance Resolution Timeframes	Source
Medi-Cal MCPs	Within 30 calendar days of receipt	DHCS <a href="#">APL 21-011</a>
Commercial full service health plans	Acknowledge receipt of the grievance within 5 calendar days; resolve the grievance within 30 calendar days.  Expedited grievances must be addressed within 72 hours.	<a href="#">CA Health and Safety Code section 1368</a>
Disability insurance	Within 30 calendar days of receipt	<a href="#">Alignment with CYBHI Policy</a>

At the conclusion of the investigation, CBH will make a determination about the appropriate resolution and communicate its decision, in writing, to the member or, in cases of minor consent, the submitting entity to relay to the student. The written communication will include all required elements as specified in state and federal law.

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<sup>63</sup> For members ages 12-17, CBH will provide written acknowledgement to the LEA or provider directly, and not to the member’s authorized representative to align with minor consent procedures and suppression of billing notifications.

CBH will log and track grievances, as well as document the resolution of the grievance. Records will be securely maintained according to regulatory requirements. CBH will provide regular reporting to DHCS on its grievance activities.

If it is determined that the grievance does not directly relate to the CYBHI Fee Schedule program and/or CBH's scope of work under its contract with DHCS, CBH will provide written notification to the member, as applicable, and the submitting entity notifying them that grievance has been forwarded to the applicable MCP or Insurer for resolution. Since LEAs/IHEs and designated providers are out-of-network providers (unless the MCP or Insurer otherwise has a contract, whereby the contract would prevail), DHCS does not anticipate a high volume of adverse benefit determinations and/or member appeals. For any appeals received, CBH will adhere to similar processes as for grievances and in alignment with state and federal requirements pertaining to timelines and noticing.

If an MCP or Insurer directly receives a grievance from a member, the MCP/insurer may opt to follow its existing procedures for grievances or it may forward the grievance to CBH for resolution. If the MCP/insurer opts to forward the grievance to CBH for resolution, it must log the grievance, provide applicable written acknowledgement of the grievance to the member and/or submitting entity, and forward to CBH within 3 business days.

## **Provider Dispute Resolution**

CBH will oversee the provider dispute resolution processes, in the event a provider has any dispute with respect to the performance or interpretation of the CYBHI Fee Schedule program requirements and/or state and federal claiming requirements. Any provider disputes that cannot be resolved by CBH will be escalated to DHCS, DMHC, and/or CDI. Further escalation may be resolved through binding arbitration pursuant to the Rules of the American Arbitration Association for Arbitration of Commercial Disputes, as applicable.

Providers may utilize the provider dispute resolution process to dispute any of the following:

- » A claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested.
- » Seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar billing or other contractual disputes that are individually numbered).
- » Disputing a request for reimbursement of an overpayment of a claim.

- » Disputing a denial for authorization of payment for not following correct authorization procedures in requesting services.

Each provider dispute submission will contain, at a minimum, the following information: provider's name, billing provider's tax ID number or provider ID number, provider's contact information, and:

- » If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CYBHI to a provider, the following must be provided: original claim form number (located on the Remittance Advice), a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.
- » If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
- » If the provider dispute involves a patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the date of services and the provider's position on the dispute, and the patient's written registration for the provider to represent said benefits.

A provider dispute must be received by CBH within 365 calendar days of the date of the remittance statement. CBH will acknowledge the dispute within 15 business days if received by mail or two business days if received electronically of the date of receipt of the provider dispute. A provider dispute that does not include all required information may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to CBH within 45 calendar days of receipt of a returned provider dispute. The written determination is sent within 45 business days of receipt of the provider dispute or the amended provider dispute. For additional information, see Appendix C, CBH's Interim Model MOU and Companion Guide.

## **Minor Consent Management**

As the state's health care authority, and the State Medicaid Agency, DHCS is uniquely aware of protected health information (PHI) protections pursuant to state and federal law, and we have taken several important steps to ensure student PHI and other sensitive data are appropriately collected, stored, transmitted, and shared in accordance

with state and federal requirements, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and California's Confidentiality of Medical Information Act.

The intersections between the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and California's Confidentiality of Medical Information Act pose unique challenges for LEAs and IHEs in determining which requirements prevail related to the provision of behavioral health services in a school setting. State and federal guidance is complex and there are many nuances in the state and federal laws, including intersections between federal requirements for obtaining parental consent under FERPA and California state law, which permits children 12 years of age and older to consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.<sup>64</sup>

Given the complexities, DHCS, in consultation with DMHC and CDI, instructed CBH to suppress all billing notifications to subscribers (i.e., parents or guardians) for the CYBHI Fee Schedule program. Given that cost-sharing is not permitted under the CYBHI Fee Schedule program, the billing notifications do not need to be provided to the subscriber.

MCPs and Insurers must also suppress all notifications to subscribers pertaining to services furnished as part of the CYBHI Fee Schedule program. This includes billing notifications, medical appointments for school-based services, and any other relevant documentation that would inadvertently notify a parent or guardian of a member 12 years of age or older that they received outpatient mental health or SUD services at a schoolsite.

## Care Coordination

Pursuant to the CYBHI Fee Schedule program Provider Participation Agreement,<sup>65</sup> LEAs, IHEs, and designated providers must coordinate care delivery with the student's MCP or Insurer and/or the county behavioral health agency (as applicable for Medi-Cal members) when any of the following conditions are met:

- » The student is experiencing a mental health crisis or is a danger to themselves or others. The CYBHI Provider is made aware by the student or the student's legal

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<sup>64</sup> [Health and Safety Code § 124260\(b\)\(1\); California Family Code § 6924\(b\)](#)

<sup>65</sup> [CYBHI Fee Schedule program Provider Participation Agreement](#)

representative that the student is actively engaged in behavioral health services with a network provider of the MCP or Insurer.

- » A CYBHI Provider determines that the student requires a referral to a level of care that is not available or appropriate in the school-linked setting (e.g., inpatient or residential treatment).
- » A CYBHI Provider determines that the student would benefit from evidence-based therapies that the CYBHI Provider does not have the capacity, training, or licensure necessary to furnish.
- » The student requires continuation of services during a period when the CYBHI Provider is out-of-session (e.g., summer or winter holidays) or otherwise unable to provide timely access to medically necessary treatment.
- » The student and/or the student's legal representative requests a referral.

CYBHI Providers must agree to share relevant and applicable treatment records and, when necessary, provide professional to professional consultation to ensure a student's MCP or Insurer network provider has the necessary documentation, information, and data necessary to provide clinically appropriate treatment to a student who is also receiving psychoeducation, screening, treatment, and/or care coordination services from the CYBHI Provider. Note: To comply with FERPA, it may be necessary for the CYBHI Provider to obtain applicable consents from the student and/or the student's parent or guardian before sharing treatment records. A release of information may be necessary to facilitate information sharing for the purposes of care coordination.

When notified, MCPs and Insurers are responsible for coordination of care in accordance with state and federal requirements, as applicable. For example, if a student receives services both under and outside of the CYBHI Fee Schedule, it is the responsibility of the MCP or Insurer to coordinate services for that student and communicate with all involved stakeholders as needed (e.g., providers, caregiver) to ensure student needs are being met.

## **OTHER APPLICABLE REQUIREMENTS**

### **Network Adequacy**

The CYBHI statewide schoolsite provider network is distinct and separate from an individual MCP or Insurer's provider network. The CYBHI Fee Schedule schoolsite provider network is not to be used, by itself, by MCPs or Insurers to satisfy any network adequacy requirements otherwise applicable pursuant to the Knox-Keene Health Care

Service Plan Act of 1975 (Knox-Keene Act) or any other relevant state laws and regulations. However, if an individual health care provider or practitioner is already included in the MCP or Insurer's provider network, or is included in the future, that individual provider or practitioner's participation in the CYBHI Fee Schedule schoolsite provider network does not disqualify them from also being in the MCP or Insurer's network.

## **Utilization Management**

MCPs and Insurers must not reduce member benefits or limit access to its outpatient behavioral health services provider network because a member is receiving services from a CYBHI Provider. Further, if a CYBHI Provider furnishing services to a member through a LEA or IHE provider contacts the MCP or Insurer to request the member be seen by an in-network provider, to 1) obtain services not available through the CYBHI Fee Schedule program or 2) to access a level of care beyond what can reasonably be provided in a school-linked setting, the MCP or Insurer must contact the member to arrange an appointment with an in-network provider. If no in-network provider is available, the MCP or Insurer must arrange for an appointment with an out-of-network provider, pursuant to state law including any applicable laws regarding patient privacy, confidentiality, and sensitive services.<sup>66</sup> Use of CYBHI Fee Schedule services, however, does not create an obligation by the member to transition to in-network care, and shall not prevent a member from using both CYBHI Fee Schedule services and in-network behavioral health services concurrently.

## **Reporting Requirements**

To the extent the MCP or Insurer has necessary data and information, DHCS, DMHC and CDI expect MCPs and Insurers to meet mandatory reporting obligations pertaining to services furnished to MCP or Insurer-enrolled students as part of the CYBHI Fee Schedule program. In cases where the MCP or Insurer does not have necessary data and information required for reporting, the MCP or Insurer must notify, in writing, the applicable state-regulator of the deficiency and the expected timeframe for remediating the deficiency based on the MCP or Insurer's Interim Model or ASO Model implementation status.

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<sup>66</sup> [Health and Safety Code § 1374.72](#) and [1374.721](#); [Insurance Code § 10144.5\(d\)](#) and [10 Cal. Code Regs. section 2240.1\(e\)](#).

## **Monitoring CBH Compliance with Program Requirements and State and Federal Laws and Regulations**

For the purposes of the CYBHI Fee Schedule program, MCPs and Insurers are not responsible for monitoring CBH's compliance with CYBHI Fee Schedule program requirements, including but not limited to provider enrollment and screening, timely claims payments, claims denials, recovery of overpayments, and grievances. MCPs and Insurers will not be held responsible for CBH's non-compliance with state or federal laws and regulations, contract requirements or other State Regulator guidance. DHCS will monitor CBH's compliance with these requirements and will initiate corrective actions, as applicable. DHCS will coordinate with DMHC and CDI, as applicable and appropriate.

Notwithstanding the above, MCPs and Insurers are responsible for complying with all program requirements that directly or indirectly affect CBH's ability to comply with such requirements. These program requirements are detailed throughout this Manual, as well as the Interim MOU and ASO MOU.

## APPENDIX A – GLOSSARY OF TERMS

The following terms are also defined in the Interim MOU Agreement.

ASO Payment Model means the model that includes the eligibility and encounter file exchanges, as well as some components of the Interim Clean Claim Payment Model as directed by DHCS.

Covered services (i.e., CYBHI Fee Schedule Services) are those outpatient mental health and substance use disorder (SUD) services specified in DHCS' published CYBHI Fee Schedule, when furnished to students twenty-five (25) years of age or younger at a schoolsite, in accordance with state law. See Welfare and Institutions Code section 5961.4; Health and Safety Code section 1374.722; and Insurance Code section 10144.53

Clean Claim is a claim or bill for covered services that has no defect, impropriety, or lack of substantiating documentation. The claim includes the information necessary to meet the requirements for encounter data (clinical information and data with content and in a format that comports with the HIPAA 837 requirements), and uses a completed CMS-1500 form or respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), that is received timely from an eligible Provider, and complies with standard industry coding guidelines, and/or other government program requirements where applicable. The claim requires no further documentation, information or alteration in order to be processed and paid timely. Claims or bills from a participating Provider who is under investigation for fraud or abuse are not Clean Claims.

Complete Claim means a claim or portion thereof including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined in the California Code of Regulations, Title 28, § 1300.71(a)(10), "information to determine payer liability" as defined in § 1300.71(a)(11). See California Code of Regulations, Title 28, § 1300.71.

Confidential Proprietary Information is any non-public proprietary information of the parties respectively, including without limitation, business plans and processes, customer/Member lists and information, financial records, methodologies, intellectual property, trade secrets, and other proprietary information, MCP or Insurer records, MCP or Insurer website(s) and passwords to MCP or Insurer website(s), information about fees, computer software, business procedures and manuals, data review criteria, manager's website, passwords to CBH website(s), CBH Provider Network databases and

directories, CBH Provider Network contract rates, and CBH Case Management & Utilization Review programs. For purposes of this Agreement, Confidential Proprietary Information does not include: (a) information publicly available by means other than wrongful disclosure or lawfully obtained from third parties without any confidentiality obligations; (b) information which is required by law or by a government agency to be disclosed by a party; provided that such party immediately notifies the other party of the requirements for such disclosure and reasonably cooperates in obtaining any protective order desired by the other party, at the other party's expense, with regard to such information; (c) information independently developed by the other party; (d) Member Protected Health Information; or (e) information provided to the other party with the intention that it be published, disseminated, released or distributed by such other party to Members, participating Providers, or to the general public.

CYBHI Fee Schedule program means the statewide, multi-payer, school-linked fee schedule program established by DHCS, pursuant to the Welfare and Institutions Code section 5961.4, Health and Safety Code section 1374.722, and Insurance Code section 10144.53.

FERPA means The Family Educational Rights and Privacy Act (FERPA) codified at 20 U.S.C. § 1232g, and the FERPA regulations codified at 34 CFR Part 99.

HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated there under, each as may be amended from time to time.

Insurer means a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106(b).

Interim Clean Claim Payment Model means the phase in which CBH and the MCP or Insurer will jointly carry out eligibility and payment functions of claims for the CYBHI Fee Schedule Services. Upon full implementation of the ASO Model, the Interim Model MOU will no longer be in effect.

Managed Care Plan or MCP means a health care service plan, as defined in Health and Safety Code section 1345(f). MCP includes both Medi-Cal and commercial lines of business. MCPs must be licensed by the Department of Managed Health Care, as applicable.

Member means an individual who is enrolled and receives health insurance coverage from an MCP or Insurer and who meets all of the eligibility requirements for

membership in the MCP or Insurer based on the registration file received by CBH from a Provider.

MOU is a Memorandum of Understanding between the MCP or Insurer and CBH, and any amendments, exhibits, schedules, appendices, addenda and attachments hereto.

Provider means a locational educational agency (LEA), county office of education (COE), institution of higher education (IHE) or participating provider or practitioner in the DHCS CYBHI school-linked behavioral health provider network. Only participating providers or practitioners, COEs, LEAs, IHEs and designated providers and practitioners appropriately identified as part of this DHCS network will be eligible for reimbursement under the CYBHI Fee Schedule.

Non-Covered Services means those services specified by the MCP or Insurer or DHCS as not covered benefits under the CYBHI fee schedule. A non-covered service may include services that were provided to a student not covered by the MCP or Insurer, were never performed, or were not provided by a health care provider appropriately licensed or authorized to provide the services.

Protected Health Information ("PHI") shall have the meaning as defined in 45 C.F.R §160.103 and/or applicable state law, but shall also include "Patient Identifying Information" ("PII") as defined in 42 C.F.R. Part 2, Subpart B, §2.11.

"Schoolsite" has the meaning described in [Section 1374.722\(b\)\(6\) of the California Health and Safety Code and Section 10144.53\(b\)\(6\) of the Insurance Code](#).

State Regulators means the California Department of Managed Health Care (DMHC), California Department of Health Care Services (DHCS), and California Department of Insurance (CDI).

## **APPENDIX B – CARELON BEHAVIORAL HEALTH SCOPE OF WORK (DHCS AGREEMENT # 23- 30348)**

<https://www.dhcs.ca.gov/CYBHI/Documents/CBH-Contract-4260-2330348-FINAL-SCOPE-OF-WORK.pdf>

## **APPENDIX C – CBH INTERIM MOU AND COMPANION GUIDE**

Final approved [Interim MOU](#) template.

Interim MOU Companion Guide – <https://s18637.pcdn.co/wp-content/uploads/sites/78/CYBHI-Multi-Fee-Schedule-Program-Participating-Plans-Interim-Model-Companion-Guide-4.pdf>

Participating Entity – Interim Onboarding Guide - [https://s18637.pcdn.co/wp-content/uploads/sites/78/Participating-Entity-Interim-Onboarding-v1.5\\_20260130.pdf](https://s18637.pcdn.co/wp-content/uploads/sites/78/Participating-Entity-Interim-Onboarding-v1.5_20260130.pdf)

Interim Model Workflow - [https://s18637.pcdn.co/wp-content/uploads/sites/78/MCP-Onboarding-Workflow-Interim-Model-DRAFT-v1.4\\_20260130.pdf](https://s18637.pcdn.co/wp-content/uploads/sites/78/MCP-Onboarding-Workflow-Interim-Model-DRAFT-v1.4_20260130.pdf)

## **APPENDIX D – ASO MODEL MOU AND SYSTEMS DISCOVERY WORKSHEET**

Final approved ASO Model MOU template – <https://s18637.pcdn.co/wp-content/uploads/sites/78/CYBHI-ASO-MOU-February-2026-revised-business-days-03032026.pdf>

ASO Business Associate Agreement - <https://s18637.pcdn.co/wp-content/uploads/sites/78/CarelonBH-Inc-CYBHI-BAA.pdf>