



Policy and Procedure No: CM 42.7	Revision No: 7
Division: Care Management	
Department: Care Management	
Title: PHC-CA Mental Health Services	
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Supersedes Policy No: 93037, CM 42.0, CM 42.1, CM 42.2, CM 42.3, CM 42.4, CM 42.5, CM 42.6	
Reviewed/Revised by: Sandy Johansson	Review/Revision Date: 12/15/2025
Approving Committee: Utilization Management Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of this policy is to define PHC California’s (the Health Plan) contractual responsibilities for the provision of mental health services with expanded outpatient coverage in accordance with Medi-Cal Mental Health Parity Final Rule CMS-2333-F and Department of Health Care Services (DHCS) All Plan Letters (APLs) 17-018 and 22-005.

Policy and Procedure:

1. The Health Plan ensures provision of the following services listed below, when medically necessary and provided by Primary Care Providers (PCPs) or by licensed mental health professionals in the Health Plan’s provider network, within their scope of practice or the Health Plan’s delegated entity:
 - a. Individual and group mental health evaluation and treatment (psychotherapy);
 - b. Psychological testing, when clinically indicated to evaluate a mental health condition;
 - c. Outpatient services for the purposes of monitoring drug therapy;
 - d. Outpatient laboratory, drugs supplies, and supplements (excluding medications listed in Attachment 2);
 - e. Psychiatric consultation

2. For mild to moderate mental health services for adults, that are covered by the Health Plan, medically necessary services are identified as “reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury.” These services include:
 - a. Diagnosing a mental health condition and determining a treatment plan;
 - b. Providing medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment, and;
 - c. Referring adults to the county for Specialty Mental Health Services (SMHS) when a mental health diagnosis covered by the Health Plan results in significant impairment where services required to treat the condition fall outside of the existing contract.

3. Consistent with the No Wrong Door policy described in APL 22-005, the Health Plan ensures the timely provision of clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) even when:
 - a. An enrollee accesses NSMHS prior to diagnosis, during assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;
 - b. An enrollee's individual treatment plan does not include NSMHS;
 - c. An enrollee has a co-occurring mental health condition and substance use disorder (SUD);
or
 - d. An enrollee is receiving NSMHS and SMHS services concurrently, if those services are coordinated and not duplicated.
4. At any time, enrollees can opt to seek and obtain a mental health assessment from a licensed mental health provider within the Health Plan's contracted network.
 - a. The Health Plan monitors the completion of mental health screenings of its enrollees by PCPs at the monthly Department of Medicine (DOM) Joint Operations Meeting (JOM).
 - b. The Managed Care Compliance Committee (MCCC) also monitors the completion of mental health screenings by PCPs on a quarterly basis.
 - c. PCPs further assess enrollees who screen positive or refer them accordingly to network licensed mental health providers.
 - d. PCPs and those licensed mental health providers in the Health Plan's network can use approved clinical tools provided on the Los Angeles County Department of Mental Health (LACDMH) website: <https://dmh.lacounty.gov/for-providers/clinical-tools/>.
5. Enrollees who experience a psychiatric emergency after hours may access care at any Emergency Department without prior authorization by the Health Plan. The Health Plan also provides a Nurse Advice Line available twenty-four (24) hours a day, seven (7) days a week, to assist and triage enrollees in the event of an emergency.
 - a. The Health Plan makes best efforts to ensure that an enrollee's existing mental health Provider is notified during an Urgent Care situation, when possible. The Health Plan allows the enrollee's existing mental health Provider to coordinate care with LACDMH or emergency room personnel for Urgent Care.
 - b. The Registered Nurse Care Team Manager is responsible for notifying an enrollee's PCP and existing mental health provider of Emergency Department visits.
6. In addition to outpatient services, the Health Plan covers and pays for all Medically Necessary Covered Services for the enrollee, including the following services:
 - a. Emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR), including facility and professional services and facility charges claimed by emergency departments, all professional physical, mental, and substance use treatment services, 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 enrollee (except those services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other specialty mental health providers).

- b. Facility charges for emergency room visits that do not result in psychiatric admission.
- c. All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of an enrollee's mental health condition.
- d. Emergency medical transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title 22, CCR, Section 51323. All non-emergency medical transportation services to access Medi-Cal covered mental health services, subject to written prescription by a Medi-Cal specialty mental health provider, except when the transportation is required to transfer the enrollee from one facility to another, for the purpose of reducing the local Medi-Cal mental health program's cost of providing services.
- e. Medically Necessary Covered Services after the Health Plan has been notified by a specialty mental health provider that an enrollee has been admitted to a psychiatric inpatient hospital, including the initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services. However, notwithstanding this requirement, the Health Plan is not responsible for room and board charges for psychiatric inpatient hospital stays by enrollees.
- f. Services that are "medically necessary" or a "medical necessity," in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS, are covered by the MCP as EPSDT services.
- g. All Medically Necessary Medi-Cal covered psychotherapeutic drugs for enrollees not otherwise excluded under this contract.
 - i. Reimbursement for covered psychotherapeutic drugs prescribed by out-of-plan psychiatrists for enrollees.
 - ii. The Health Plan may require that prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the contractor's provider network.
 - iii. Reimbursement to pharmacies for those psychotherapeutic drugs as detailed in the signed contract between the Health Plan and DHCS.
- h. The Health Plan is required to provide covered services through the PCP and contracted mental health provider network when possible and to apply utilization review controls for these services, including prior authorization, consistent with the Health Plan's obligation to provided covered services under this contract Reference UM 22.1 for specific details on timeliness standards for authorization of services per California Health and Safety Code (HSC)1367.01. See Utilization Management Policy and Procedure PHC-CA Authorization Referral Process.
- i. The Health Plan continues to cover and ensure the provision of primary care and other services unrelated to mental treatment and coordinate services between the PCP and the

psychiatric service providers.

j. SMHS remains a carve-out within the Health Plan's contract with DHCS. The Health Plan continues to refer enrollees who require SMHS to the Los Angeles County Department of Mental Health (LACDMH). Reference Attachment A – Access to Medi-Cal Specialty Mental Health Services (SMHS). SMHS include, but are not limited to:

- i. Day treatment intensive services
- ii. Day rehabilitation services
- iii. Crisis interventions services (i.e., acute suicidal and homicidal ideation)
- iv. Crisis stabilization services
- v. Targeted case management (TCM) services

k. Residential services (adult and crisis treatment services)

5. The Plan and its beneficiaries can reference Attachment 1 of APL 17-018 for a complete list of services provided categorized by Mild to Moderate, Significant Impairment requiring SMHS and Emergency and Inpatient Services. (Refer to Attachment B)
6. The Health Plan refers enrollees who require TCM services. If upon notification from DHCS that Members are receiving TCM services the Contractor is not already aware of, the Health Plan reaches out to local government agencies (LGAs) to coordinate care, as appropriate. Referral contact information is found on the Medi-Cal Administrative Activities and TCM website <https://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx> or call Bruce Pressler directly at 916.552.9284, email bruce.pressler@dhcs.ca.gov.

a. TCM Services include the following:

- i. A documented assessment identifying the enrollee's needs. The assessment supports the selection of services and assistance necessary to meet the assessed needs and includes the following, as relevant to each enrollee:
 - a) Medical/mental condition
 - b) Physical needs, such as food and clothing
 - c) Social/emotional status
 - d) Housing/physical environment
 - e) Familial/social support system
 - f) Training needs for community living
 - g) Educational/vocational needs
- ii. Development of a comprehensive, written, individual service plan, based upon the

assessment specified above. The plan is developed in consultation with the enrollee and/or with the enrollee's family or other social support system. The plan is in writing and, as relevant to each enrollee, documents the following:

- a) The nature, frequency, and duration of the services and assistance required to meet identified needs
 - b) The programs, persons and/or agencies to which the enrollee is referred
 - c) Specific strategies to achieve specific enrollee outcomes
 - d) Case manager supervisor's signature.
- iii. Implementation of the service plan includes linkage and consultation with and referral to providers of service. The case manager follows up with the enrollee and/or provider of service to determine whether services were received and whether the services met the needs of the enrollee. The follow-up occurs as quickly as indicated by the assessed need but does not exceed 30 days from the scheduled service.
- iv. Assistance with accessing the services identified in the service plan includes the following:
- a) Arranging appointments and/or transportation to medical, social, educational, and other services.
 - b) Arranging interpretation and/or translation services to facilitate communication between the enrollee and the case manager, or the enrollee and other agencies or providers of service.
- v. Crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate, or reduce a crisis situation for a specific enrollee.
- a) For the target populations defined in Section 50262.7(a)(2), crisis assistance planning is restricted to non-medical situations.
- vi. Periodic review of the enrollee's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified, or discontinued. The review or reinvestigation is:
- a) Completed at least every six (6) months;
 - b) Conducted by the case manager in consultation with the enrollee and/or in consultation with the enrollee's family or social support system; and
 - c) Approved by the case manager's supervisor
- vii. Any modifications to the service plan are made in writing and become an addendum to it.

- b. Because TCM can be a direct duplication of services such as, but not limited to, Basic Population Health Management (PHM), Critical Care Management (CCM), Enhanced Care Management (ECM), and Community Supports, the Health Plan's Registered Nurse Care Team Manager (RNCTM) coordinates care with LGAs to ensure Members receiving TCM are not receiving duplicative services.
7. The Health Plan conducts activities to improve the coordination of behavioral healthcare and general medical care annually, including:
- a. Collaborating with behavioral healthcare practitioners
 - b. Quantitative and qualitative analysis of data to identify improvement opportunities
 - c. Identifying and selecting one opportunity for improvement
 - d. Identifying and selecting a second opportunity for improvement
 - e. Taking collaborative action to address one identified opportunity for improvement
 - f. Taking collaborative action to address a second identified opportunity for improvement
8. In accordance with Title 9, CCR, Chapter 11, the Health Plan is responsible for maintaining appropriate Memorandums of Understanding (MOUs) with mental health providers to execute the necessary mental services as described in the contract and within this policy. The MOU is the primary mechanism for ensuring enrollee access to medically necessary mental health services (refer to Attachment B). The MOU includes the following elements listed below:
- a. Basic Requirements;
 - b. Covered Services and Populations;
 - c. Oversight Responsibilities of the MCP and MHP;
 - d. Screening, Assessment, and Referral;
 - e. Care Coordination;
 - f. Information Exchange;
 - g. Reporting and Quality Improvement Requirements;
 - h. Dispute Resolution;
 - i. After-Hours Policies and Procedures; and
 - j. Enrollee and Provider Education.
9. The Health Plan resolves disputes with the Los Angeles County Department of Mental Health Services

pursuant to Title 9, CCR, Section 1850.505 according to the procedures as noted in the Health Plan's standard operating procedure Provider Dispute Resolution. Any decision rendered by DHCS and the California Department of Mental Health regarding a dispute between the Health Plan and LACDMH concerning provision of mental health services or Covered Services required under this Contract is subject to the dispute procedures specified in Exhibit E, Attachment 2, provision 19 regarding Disputes as noted in the DHCS contract with the Health Plan.

Definitions:

1. Medical Necessity – Services are “medically necessary”, or a “medical necessity” as defined with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS, are covered by the MCP as EPSDT services.

Monitoring:

The Utilization Management Committee (UMC) reviews mental health utilization data and provides network access routinely at regularly scheduled meetings. Committee members review data and provide oversight and feedback to facilitate improved quality operations, care management, and utilization efforts.

The UMC reviews, updates, if necessary, and approves this Policy and Procedure at least annually.

Reference(s):

1. Title 42, CFR 438.930
2. Title 42, CFR 438.915(a)
3. Title 42, CFR 438.915(b)
4. Medi-Cal Mental Health Parity Final Rule CMS-2333-F
5. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-021, Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services, December 13, 2013.
6. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-018, Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans, November 27, 2013.
7. Title 22 CCR 51351
8. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005, No Wrong Door for Mental Health Services Policy, March 30, 2022.
9. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-018, Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services (Supersedes APL 13-021), October 27, 2022.
10. DHCS OR Contract #22-20597, Exhibit A, Attachment III, 4.3.12 Targeted Case Management (TCM) Services



11. Title 9, CCR, Chapter 11

12. California Health and Safety Code 1367.01

13. <http://www.dhcs.ca.gov/provgovpart/Pages/TCMContactInformation.aspx>

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
9/15/2023	CM 42.5	Dept. of Health Care Services (DHCS)	2024 OR R.0133 AIR1	Approved
10/24/2023	CM 42.5	DHCS	2024 OR R.0207	Approved
11/7/2023	CM 42.4	DHCS	2024 Operational Readiness (OR) R.0117	AIR1
Not avail.	CM 42.5	DHCS	2024 OR R.0212	Approved
Not avail.	CM 42.5	DHCS	2024 OR R.0222 AIR1	Approved
Not avail.	CM 42.5	DHCS	2024 OR R.0213 AIR1	Approved
11/30/2023	CM 42.6	DHCS	2024 OR R.0117 AIR1	Approved
TBD	CM 42.6	DHCS	D.0330.33	Pending
TBD	CM 42.6	DHCS	D.0330.45	Pending
TBD	CM 42.6	DHCS	D.0410	Pending
TBD	CM 42.6	DHCS	D.0415	Pending
TBD	CM 42.6	DHCS	D.0416	Pending
12/17/2025	CM 42.6	Dept. of Managed Health Care (DMHC)	Filing 20254196-4	Comment Table
12/18/2025	CM 42.7	DMHC	Filing 20254196-6	Pending

Attachment A

Access to Medi-Cal Specialty Mental Health Services (SMHS)

Level of Need	Indicators	Disposition	Who to Call
Emergency	<ul style="list-style-type: none"> Acutely suicidal or homicidal At risk of immediate harm 	911 response PMRT response Urgent Care Center Referral	911 800-854-7771 (24/7 access)
Urgent Need for Assessment	Meet DMH threshold criteria on screener	Outpatient specialty mental health appointment scheduled	855-425-8141
Routine Appointments	Meet <u>all</u> below: <ul style="list-style-type: none"> Medi-Cal Specialty Mental Health Included Diagnosis (*) Significant functional impairment in key roles (e.g. work, home, self-care) Expectation that proposed interventions can impact patient's condition Condition will not be responsive to physical health care-based treatments 		Options: <ul style="list-style-type: none"> Health Neighborhood Partner (Attachment A) Service Area Navigator (Attachment B) ACCESS: 1-800-854-7771 Individual calls or walks in to specialty mental health providers (**)
	If does <u>not</u> meet all above		<ul style="list-style-type: none"> Applicable Managed Care Plan (Behavioral Health line on Member's ID Card.)

Screener: Urgent Behavioral Health Screening Form to Obtain Specialty Mental Health Assessment

Attachment A: Health Neighborhood Provider Partnership Listing (in development)

Attachment B: DMH Service Area Navigator Roster

**Included Diagnosis: Pervasive Developmental Disorders except Autistic Disorder, Attention*



Deficit & Disruptive Behavior Disorders, Feeding & Eating Disorders of Infancy or Early Childhood, Elimination Disorders, Other Disorders of Infancy, Childhood or Adolescence, Schizophrenia & other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorders, Eating Disorders, Impulse- control Disorders not elsewhere classified, Adjustment Disorders, Personality Disorders excluding Antisocial Personality Disorders, Medication - Included Movement Disorders

**Info on http://dmh.lacounty.gov/wps/portal/dmh/for_providers

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

DIMENSION	MCP	MHP ¹⁰ OUTPATIENT	MHP INPATIENT
ELIGIBILITY	<p>Mild to Moderate Impairment in Functioning</p> <p>A beneficiary is covered by the MCP for services if he or she is diagnosed with a mental health disorder, as defined by the current DSM¹¹, resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning:</p> <ul style="list-style-type: none"> • At an initial health screening, a PCP may identify the need for a thorough mental health assessment and refer a beneficiary to a licensed mental health provider within the MCP's network. The mental health provider can identify the mental health disorder and determine the level of impairment. • A beneficiary may seek and obtain a mental health assessment at any time directly from a licensed mental health provider within the MCP network without a referral from a PCP or prior authorization from the MCP. • The PCP or mental health provider should refer any beneficiary who meets medical necessity criteria 	<p>Significant Impairment in Functioning</p> <p>An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria:</p> <ol style="list-style-type: none"> 1. Has an included mental health diagnosis;¹² 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function; 3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning. 4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care based treatment. <p><i>Note: For beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels</i></p>	<p>Emergency and Inpatient</p> <p>A beneficiary is eligible for services if he or she meets the following medical necessity criteria:</p> <ol style="list-style-type: none"> 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: <ol style="list-style-type: none"> a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent

DIMENSION	MCP	MHP ¹⁰ OUTPATIENT	MHP INPATIENT
ELIGIBILITY (continued)	<p>for SMHS to the MHP.</p> <ul style="list-style-type: none"> When a beneficiary's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the beneficiary may return to the MCP's network mental health provider. <p><i>Note: Conditions that the current DSM identifies as relational problems are not covered (e.g., couples counseling or family counseling.)</i></p>	<p><i>to correct or ameliorate a mental health condition or impairment.¹³</i></p>	<p>or emergency intervention provided in the community or clinic; and;</p> <p>f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.</p>
SERVICES	<p>Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> Individual and group mental health evaluation and treatment (psychotherapy) Psychological testing when clinically indicated to evaluate a mental health condition Outpatient services for the purposes of monitoring medication therapy Outpatient laboratory, medications, supplies, and supplements Psychiatric consultation 	<ul style="list-style-type: none"> Mental Health Services <ul style="list-style-type: none"> Assessment Plan development Therapy Rehabilitation Collateral Medication Support Services Day Treatment Intensive Day Rehabilitation Crisis Residential Treatment Adult Residential Treatment Crisis Intervention Crisis Stabilization Targeted Case Management Intensive Care Coordination Intensive Home Based Services Therapeutic Foster Care Therapeutic Behavioral Services 	<ul style="list-style-type: none"> Acute psychiatric inpatient hospital services Psychiatric Health Facility Services Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

Attachment D

Adult and Youth Screening and Transition of Care Tools

DHCS offers Medi-Cal Mental Health Services' guidance, screening and transition tools, and translated versions of those tools on their website: <https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx>. The screening and transition tools are fillable, interactive PDF forms; download the most current versions from the DHCS website link above.

Before using the screening and transition tools, refer to information in the following guidance documents:

- Behavioral Health Information Notice (BHIN) 22-065, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services, <https://www.dhcs.ca.gov/Documents/BHIN-22-065Adult-and-Youth-Screening-and-Transition-of-Care-Tools-for-Medi-Cal-MHS.pdf> and
- All Plan Letter (APL) 22-028, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services, <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-028.pdf>